Healthcare Transformation Collaboratives Cover Sheet

1. Collaboration Name: Innovating for Equity….. Engaging Community Members to Transform the Healthcare Delivery System

2. Name of Lead Entity: Illini Community Hospital

3. List All Collaboration Members:

Illini Community Hospital

Blessing Corporate Services

Transitions of Western Illinois

Mental Health Centers of Western Illinois

Adams County Health Dept.

Southern Illinois University

United Way of Adams County

4. Proposed Coverage Area: West-Central Illinois

5. Area of Focus: The overall outcome of the proposed collaborative is to improve the health outcomes, improve quality and decrease costs of caring for the Medicaid population we serve by transforming the delivery system into a comprehensive, community-based system of care. The project has two goals:

Goal 1: Develop an engagement strategy to address inequities, including racial, in the existing service delivery system and social determinants of health barriers that result in disparities in individuals' ability to access care.

Goal 2: Engage the target population to develop and expand services to address identified gaps and to facilitate access and linkages to medical, behavioral health and social services. The areas that are targeted through the innovation are behavioral health and substance abuse, access to care – including chronic disease – care coordination, social determinants of health, and maternal/child health.

6. Total Budget Requested: $22,495,289

1. Community Partners

The community partners were selected based upon their role in helping the target population improve health outcomes. Partners include hospitals, health systems, community-based organizations, Federally Qualified Health Centers, Community Mental Health Centers, and Health Departments. Each partner has contributed to the development of the proposed innovation and has committed to execution of the plan. The partners provide medical care and also address social determinants of health. The partners have a long history of working together and are committed to collaborating to find new ways to improve people's lives. As the project moves to implementation, additional partners who meet identified needs may be added in order to ensure the success of the proposed innovation.

Illini Community Hospital – Illini Community Hospital is a small, 25-bed Critical Access Hospital located in rural Pike County, Illinois. Illini Community Hospital will serve as the lead entity and fiscal agent for the proposed project. Illini Community Hospital receives Medicaid payments.

Blessing Health System – Blessing Health System is an integrated health system consisting of three affiliated hospitals (including Illini Community Hospital), two physician groups, an accredited college of nursing and health sciences, a network of medical specialty businesses, and a charitable foundation. Blessing Health System is located in Quincy, Illinois which is the largest community in the area. The health system provides services for a rural 23-county area and communities within a hundred-mile radius. The Blessing Health System receives Medicaid payments.

Transitions of Western Illinois – Transitions of Western Illinois is located in Adams County and is a charitable, not-for-profit agency that provides a comprehensive array of mental health, educational, and rehabilitation services. Transitions serves people of all ages who have a developmental disability and/or a mental illness, as well as people who are having emotional adjustment problems. Transitions was founded in 1955 as the Adams County Mental Health Center. For nearly 60 years the agency has served the Adams County area, providing high quality, affordable mental health and rehabilitation services. Transitions has expertise in provision of community-based intensive, care management services to individuals with behavioral health conditions.

Mental Health Centers of Western Illinois (MHCWI) – MHCWI offers emotional vocational, social and financial wellness help for residents of Brown, Pike and Hancock Counties. The mission of MHCWI is to help each individual achieve personal wellness through the provision of cost-effective, person-centered services by qualified and caring staff.

Adams County Health Department – Adams County Health Department is the local public health agency that assures high-quality public health services are available to all citizens of Adams County, based on client and community needs. They also have expertise in maternal/child health and management of social determinants, which is an important part of the proposed program.

Southern Illinois University Federally Qualified Health Center – Southern Illinois Center for Family Medicine was established in 1970 to assist patients in central Illinois to meet their healthcare needs through education, patient care, research, and service to the community. SIU is a Federally Qualified Health Center and has an affiliated residency program. SIU Federally Qualified Health Center receives Medicaid payments.
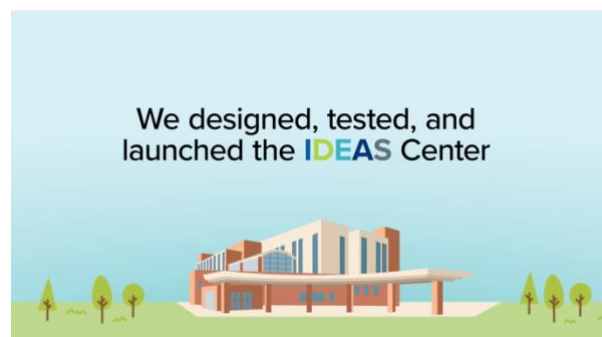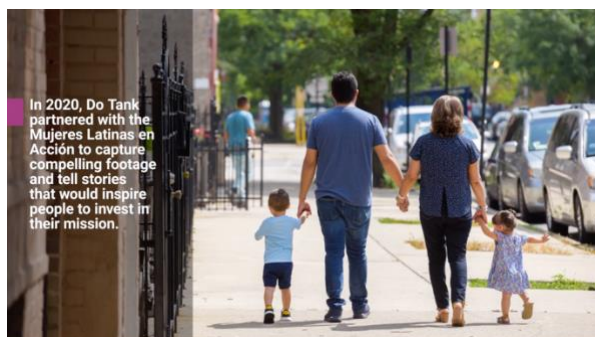
United Way of Adams County – For over 60 years, the focus of the United Way of Adams County has been identifying and resolving pressing community issues as well as making measurable changes in the communities through partnerships with schools, government agencies, businesses, organized labor, financial institutions, community development corporations, voluntary and neighborhood associations, and the faith community. The United Way of Adams County is a leader in community engagement and community health needs assessment and planning initiatives.

Contracted Partners that will play a role in designing and implementing the proposed innovation:

ATW Health Solutions- ATW was established in 2014 and is a U.S. Small Business Administration 8(a) Women-Owned Small Business healthcare advisory and consulting firm. ATW is certified by the Illinois Business Enterprise Program (BEP). ATW, led by Dr. Knitasha Washington, DHA, MHA, FACHE, is a consulting company that is nationally recognized for building and implementing quality programs and initiatives. ATW is a leader is aligning equity/diversity and inclusion strategies with a Person and Family Engagement design and evaluation. The team is comprised of national experts on the topic of health disparities in communities of all compositions. ATW is deeply experienced in the development of health care policy with a focus on minority health initiatives and vulnerable populations. "The perspectives and values of real people with real lived experiences using the healthcare system are always brought into our work".- Dr. Knitasha Washington

Do Tank Health – Do Tank is a human-centered design firm made up of strategists, innovators, facilitators, designers, and developers and based in Chicago, which primarily serves healthcare organizations ranging from pharma and medical device companies to associations and health systems. Its innovation methods involve the use of visual tools that serve as structures for capturing complex conversations (in both physical and virtual settings), distilling insights from those conversations, and assembling the insights into a coherent strategy. These methods have proven useful for engaging hourly workers and members of the community in places as disparate as Bakersfield, Milwaukee, and the Bronx. Do Tank uses design thinking principles to simplify complexity, align teams, and turn ideas into energy and action. As a company, Do Tank has deep experience working with Illini Community Hospital and the Blessing Health System; several of its projects have helped make an impact in Western Illinois communities. These include: testing remote patient monitoring for moderate Covid cases, helping secure funds for biomarker and cancer care work, and running a Hotwash process to improve upon 13 different departments' responses to the pandemic.

A 2-minute summary of Do Tank's work at Blessing: https://vimeo.com/432987293/45334853f9

In 2020, Do Tank partnered with the Mujeres Latinas en Acción to capture compelling footage and tell stories that would inspire people to invest in their mission.

We designed, tested, and launched the IDEAS Center

The 2-minute summary of Do Tank's DE&I work: https://vimeo.com/520070477/a102d61d7f

2. Brief Project Description

1. Provide an official name for your collaboration. NOTE: Please ensure that this name matches the name given in the "Application Name" field in the Project Information form at the beginning of the application.

Innovating for Equity… Engaging Community Members to Transform the Healthcare Delivery System

2. Provide a one to two sentence summary of your collaboration's overall goals.

The overall outcome of the proposed collaborative is to improve the health outcomes, improve quality and decrease costs of caring for the Medicaid population we serve by transforming the delivery system into a comprehensive, community-based system of care. The project has two goals:

Goal 1: Develop an engagement strategy to address inequities, including racial, in the existing service delivery system and social determinants of health barriers that result in disparities in individuals' ability to access care.

Goal 2: Engage the target population to develop and expand services to address identified gaps and to facilitate access and linkages to medical, behavioral health and social services. The areas that are targeted through the innovation are behavioral health and substance abuse, access to care – including chronic disease – care coordination, social determinants of health, and maternal/child health.

3. Detailed Project Description: Provide a narrative description of your overall project, explaining what makes it transformational.

The service area for the project is the western Illinois counties of Adams, Brown, Pike and Hancock. Following is a map depicting the targeted communities and the location of the collaborating partners:
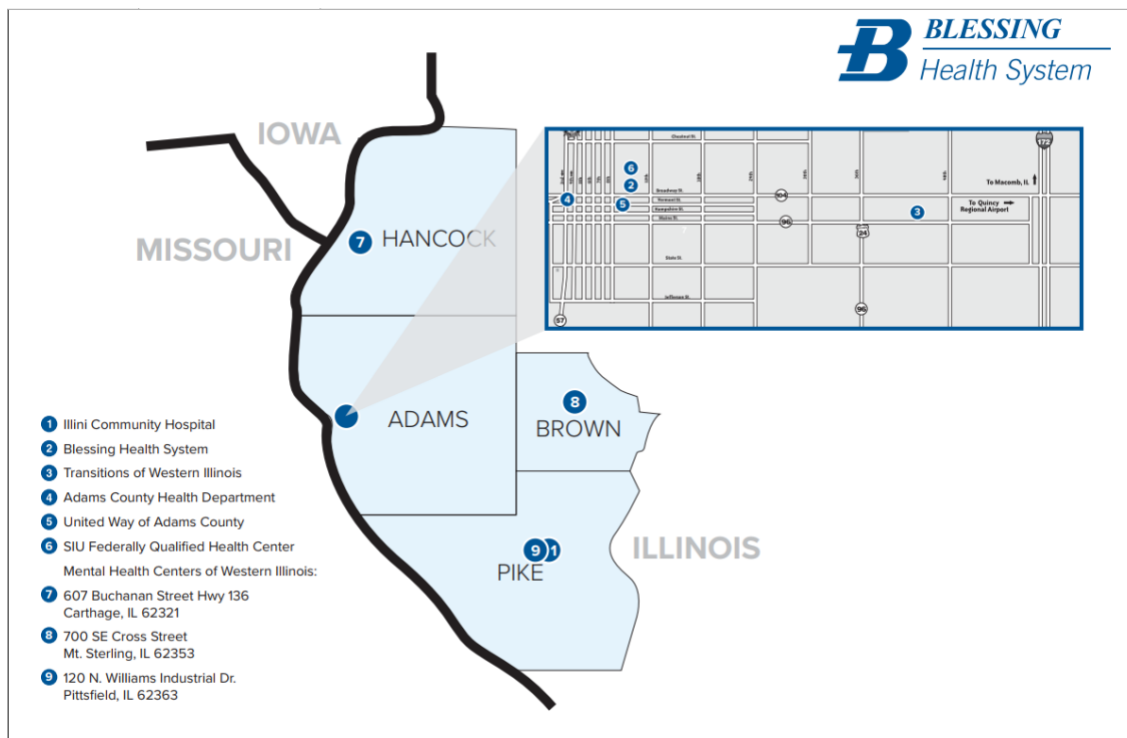
Health and social service providers have been working for years to improve access to healthcare for the disadvantaged population in the targeted communities. However, despite these efforts, concerns about health care access and patients' ability to access services has continued. The proposed innovation is transformational because it will utilize the target population—who traditionally have not had a strong voice—to help design and implement the components of the proposed project. It is challenging to fully address the root causes of the factors that lead to inequalities and to develop an effective system of care without the engagement of the target population. The innovation will allow the target population to have a voice in the design and implementation of strategies to assist in developing interventions and strategies. The innovation will redesign the care delivery system using a human-centered design approach to quality that transforms healthcare by identifying and designing the right solution to the right problem for the right people. We will utilize innovation techniques and an evidence-based approach to developing the solution. The tenets of Person and Family Engagement (PFE) and the pursuit of health equity will be foundational to the program. Patient-centeredness and equality will be used as core strategies to represent measurable inputs and outputs and result in demonstrated value.

Illini Community Hospital has partnered with Do Tank—an innovation company—and has embarked on a journey to build a stronger culture of innovation that comes from all parts of the organization. The journey has involved the incorporation of design thinking tools and skills to empower staff to accelerate projects with new ways of working. Do Tank, a global innovation firm made up of strategists, innovators, facilitators, designers, and developers has been engaged to assist with the innovation work of the organization. The processes and tools from this initiative will be incorporated into the project implementation to assure that innovation is built into all aspects of the project. The innovation design

work enhances participants' ability to think broadly and creatively and will facilitate a new, innovative approach to the redesign of the Medicaid delivery system. Do Tank will be a contracted partner to assist us in using design thinking and processes throughout the innovation.

Identify the healthcare challenges it faces,

The population in the service area faces significant risk factors and disparities in the areas of socioeconomic status and geography. The barriers faced by the target population are impactful: rurality, poverty, high rates of uninsured population and the lack of available health professionals lead to significant access-to-care issues. Rural communities have historically had fewer providers, resulting in the need for residents to travel to access healthcare services. The combination of a long distance to travel for services and the increased rate of poverty creates challenges in obtaining necessary healthcare services, which results in poor physical and mental health for the population. As a result of the many barriers to care, the patients find it challenging to achieve positive health outcomes.

Challenges exist for the target population in effectively utilizing the complex care delivery system that exists for healthcare and social services. We know that inefficiencies and communication gaps cause challenges to the target population in effectively accessing services that are needed. The care delivery system is complex and can be difficult to navigate effectively.

Other barriers were identified through the Community Health Needs Assessment (CHNA) process. Provisions in the Affordable Care Act require charitable hospitals to conduct a CHNA, which is a systematic process involving the community to identify and analyze community health needs as well as community assets and resources in order to plan and act upon priority community health needs. In the CNHA process, stakeholders identified multiple social determinants of health barriers to accessing health care services that will be addressed by the proposed project:

- Lack of coordination and awareness of health services as well as a lack of education about how to access services that are available among providers and consumers.
- Individual behaviors (exacerbated by economic issues)
  - Missed appointments
  - Inability to set up timely follow-up appointments
  - Challenges contacting individual consumers via telephone or the mail
- Limited availability of services, especially outside of Quincy
  - Capacity constraints at centers
  - No way for uninsured and Medicaid insured to determine which providers are accepting new patients, resulting in numerous fruitless contacts
- Financial issues
  - Tightening of eligibility requirements that limit what services can be provided and to whom
  - Long wait for reimbursement from the States for services provided to the Medicaid population
  - Lack of resources to provide free or subsidized care to consumers
  - Consumers' lack of resources to pay for care
- Lack of transportation
  - Economic status often results in not having a car or having a car that is not reliable
  - Reliance on family members or friends for transportation

- o Limited public transportation system
- o Challenges for those who live outside of the city of Quincy
- o Reliance on family members or friends for transportation
- o Limited public transportation system
- Feeling of being stigmatized because consumers receive Medicaid or do not have any health insurance
- Challenges in navigating the healthcare system
- High incidence of behavioral health and substance abuse

Articulate your goals in addressing these challenges:

The collaboration seeks to improve patient outcomes and reduce disparities through engagement and partnership with the targeted population to develop a systematic, seamless, community-based system of care to address social determinants of health barriers that create challenges in accessing quality healthcare services. The initiative will facilitate access and linkages to medical, behavioral health and social services. It will also innovate new initiatives or build upon existing successful initiatives to address identified service delivery gaps in maternal/child health, behavioral health and substance abuse, and care coordination through the development of an integrated system of care between the health system and the community.

Explain your strategy and how it addresses the causes of these challenges, and lay out the expected timeframe for the project. Describe any capital improvements, new interventions, delivery redesign, etc. Your narrative should explain the need for each significant item in your budget, clarifying how each connects to the overall goals and operations of the collaboration. Provide your narrative here: [Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

It is imperative that our community learns how to think differently to approach the work to truly engage the population in addressing the long-term inequities that have led to health disparities for those we serve. ATW Health Systems and Do Tank Health will guide us in engaging the population to transform our health delivery system. The overarching strategy is to develop a system approach and strategic perspective, led by consultants from ATW Health Systems, to engage the population and transform our delivery system. ATW Health Systems will assist in the development and execution of a strategy to assist us in eliminating past disparities. ATW Health Systems will serve as the neutral partner to understand the partners' role, synthesize the work, and bring a systems approach to eliminating disparities. The work will occur at multiple levels and will include learning and development, technical support, and large scale quality improvement projects using evidence-based implementation science principles to optimize and accelerate innovation. The project will serve as an incubator for innovation, allowing us to implement large scale quality improvement projects using rapid cycle techniques.

As a co-contributor to this effort, Do Tank Health will assist Blessing in its efforts to engage patients, align with community partners, and build consensus about the most effective ways to transform lives in

the region. At every stage of the work, Do Tank Health will also leverage its unique storytelling capabilities—from compelling slide decks and 1-pagers to captivating video reels. Far from being a "nice-to-have," these skills will be essential for making this effort part of the dialogue in the Quincy community and surrounding area.

Our community needs assessment and planning efforts have identified areas to target in order to improve the system of care for our community. Goal number two addresses the identified needs in six areas from the needs assessment that need to be expanded and further developed in order to have a strong infrastructure from which to deliver the needed services. The identified targeted areas are behavioral health/substance abuse, access to care, care coordination, social determinants of health, workforce, and maternal/child health.   The targeted population will be engaged to assist us in further refining the project plans to address the identified strategies.

The proposed innovation will be a five-year project. In order to successfully implement the planned innovation, a Project Manager will be hired through Illini Community Hospital.   Project management is the application of processes, methods, skills, knowledge and experience to achieve specific project objectives according to the project acceptance criteria within agreed parameters. Project management has final deliverables that are constrained to a finite timescale and budget. Project management is important because one of a project manager's duties is to ensure there's rigor in architecting projects properly so that they fit well within the broader context of our client's strategic frameworks. Good project management ensures that the goals of projects closely align with the strategic goals of the business. Project management is important because it can help to ensure the right output is delivered, that's going to deliver real value. Of course, as projects progress, it is possible that risks may emerge, that turn into issues, or even that the business strategy may change. But a project manager will ensure that the project is part of that realignment. Project management really matters here because projects that veer off course, or which fail to adapt to the business needs, may end up being expensive and/or unnecessary. Project managers serve the team but also ensure clear lines of accountability. With a project manager in place, there's no confusion about who's in charge and in control of the efforts in a project. Project managers enforce process and keep everyone on the team aligned, too; ultimately, they carry responsibility for whether the project fails or succeeds. Funding would be used to hire a project manager to maintain the scope and quality of the grant.

In addition to the project manager, telehealth staff will be hired to implement the project. A portion of the existing telehealth coordinator's time will be devoted to implementing the project, as many interventions are focused on expansion of telehealth. In addition, a patient care coordinator and virtual care quality analyst will be hired for the telehealth program. The patient care coordinator will be responsible for overseeing the daily functioning of the project. Responsibilities of the patient coordinator will include monitoring the telehealth data, working with the patients and providers to establish connection and maintain communication, assisting patients in navigating the healthcare and social service systems, and collecting/sharing data with stakeholders regarding the program. The virtual care quality analyst will be responsible for taking a leadership role in analyzing, interpreting, and presenting data from systems in order to identify opportunities, display trends, and improve processes related to telehealth opportunities and will serve as the primary resource for essential data-related functions.
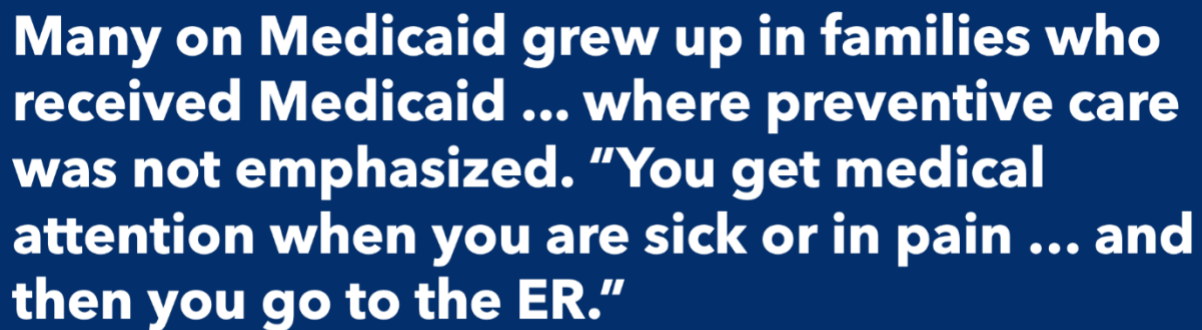
Goal 1	Develop an engagement strategy to **address inequities – including racial – in the existing service delivery system** and **address the SDOH barriers** that create disparities in individuals' ability to access care
Strategy 1.1	Measurement and Research—Identifying and Understanding Patient Population, Experiences, Outcomes and Disparities
Strategy 1.2	Organizational Partnership—Working with Diverse Partners to Identify Problems and Potential Solutions
Strategy 1.3	Care, Policy, and Process Redesign—Adapting to Meet Identified Needs Better
Goal 2	**Engage the target population to create new initiatives or build upon existing ones,** to address service delivery gaps
Strategy 2.1	Behavioral Health and Substance Abuse
Strategy 2.2	Access To Care
Strategy 2.3	Care Coordination
Strategy 2.4	Social Determinants of Health
Strategy 2.5	Workforce Development: Grow the workforce and provide evidence-based training
Strategy 2.6	Maternal and Child Health

Following is a discussion of the strategies that will be implemented through the proposed project. The strategies were identified to address the areas of need identified in the assessment and the identified challenges that are faced by the target population:

Goal 1: The goal of the collaboration is to develop an engagement strategy to address inequities – including racial – in the existing service delivery system and to addresses the social determinants of health barriers that result in disparities in individuals' ability to access care.

Participating Partners: All partners will fully participate in all strategies and goals in Goal 1. The activities will be led by ATW Health in partnership with Do Tank Health. The United Way of Adams County will assist in this effort of community organization, engagement, and evaluation.

This goal and related strategies are important, as community members indicated in their interviews that a top priority is to gather information from the targeted community. It was noted that we must develop trust and treat the population respectfully. It is important to learn the perspective, values, and perception of the target population. "'will I be treated with respect, and 'will I be heard?' are concerns. Another interesting perception was noted that healthcare may not be as important to the Medicaid population as it is to us as providers. Many on Medicaid grew up in families who received Medicaid and in families where preventive care was not emphasized … 'you get medical attention when you are sick or in pain … and then you go to the ER.'"

> **Many on Medicaid grew up in families who received Medicaid … where preventive care was not emphasized. "You get medical attention when you are sick or in pain … and then you go to the ER."**

Strategy 1.1: Measurement and Research—Identifying and Understanding Patient Population, Experiences, Outcomes and Disparities

> Objective1.1a: Establish a performance improvement management system to collect and assess data about the patients and families served by the collaborative, disparities in care quality and safety among them, social issues affecting the surrounding communities, and the collaborative's workforce and resource capacity.
>
> In order to complete this objective, we will create a systems assessment that analyzes disparities and identifies gaps in care delivery and other factors that may influence health outcomes. Following this, we will design a data architecture framework using quantitative and qualitative measures for regular reporting. The framework will include SDOH data and other equity metrics i.e., REaL data.   An Equity Scorecard will be customized for the collaborative, and leaders will be trained on the use of the tool for ongoing performance management. We will collect data and examinee quality and safety performance indicators, as well as PFE measures, by demographic and socioeconomic subgroups of patients. This process will systematize stakeholder engagement activities to collect qualitative data in support of understanding patient and community experiences and needs. The community health needs assessment will be utilized to identify the most pressing social determinants of health for the community and link them to impacts on health and health care. Finally, staff composition of the collaborative members will be assessed to determine if it accurately reflects the patient populations and communities served by the hospital. We will also document and monitor the use of services and supports related to the provision of culturally and linguistically appropriate services.

Strategy 1.2: Organizational Partnership—Working with Diverse Partners to Identify Problems and Potential Solutions

> Objective 1.2a: Create strong organizational partnerships with diverse stakeholders representing patients, families, and community partners can help the collaborative take actions toward improving the coordination and equitable delivery of high-quality, safe health care.

In order to complete this objective, cultural and community leaders will be identified through social service agencies, nonprofit organizations, and community and social institutions (e.g., churches and schools) in the community. We will collaborate with identified partners to address disparities in care quality and safety. Effective and sustainable partnerships will be created by intentionally including as many diverse partners as possible, acknowledging their perspectives and values, establishing clear and consistent communication, and demonstrating willingness to tackle issues collaboratively. Finally, we will activate and mobilize a network of diverse stakeholders to educate and inform the community on key areas of focus for impact, including but not limited to health disparities in diseases and chronic conditions such as heart disease and diabetes. Our educational interventions will be designed to increase access to primary and specialty care while removing barriers such as insurance, transportation, and care navigation.

Strategy 1.3: Care, Policy, and Process Redesign—Adapting to Meet Identified Needs Better

Objective 1.3a: Work collaboratively to create policies and implement redesigned care practices that directly address patient-family, community-identified needs and eliminate disparities.

In order to complete this objective, we will conduct an Integrated Patient Family Engagement Assessment to identify changes that are necessary, the collaborative members' readiness to implement those changes, and the resources and infrastructure necessary to execute changes successfully. A work plan will be developed to improve care delivery processes and to ensure that all patients receive the same level of quality and safety in care, which may require greater investment in the collaborative's infrastructure and workforce. Community, patient, and family partners will be consulted to help identify low- or no-cost alternative methods for addressing barriers. Finally, we will make tangible changes that improve care experiences for patients, particularly those from vulnerable populations.

Goal 2: The goal of the collaboration is to develop and expand services to address identified gaps and to facilitate access and linkages to medical, behavioral health, and social services. Areas addressed through this goal include behavioral health and substance abuse, access to care – including chronic disease – care coordination, social determinants of health, and maternal/child health.

In order to accomplish this goal, we will create innovative approaches to reaching and serving the population through engaging key members of the target population and identifying strategies to connect medical and behavioral health services to the entire family system in a holistic manner. The goal is to identify both low-tech and higher-tech ways of connecting the target population with vitally needed services and improving communication between medical and behavioral health providers regarding family system needs. Our strategy is to improve outcomes for the population of focus, by enrolling "high-risk" individuals in care coordination and other support services to decrease utilization of high-cost services (e.g., ED visits; hospitalizations), linking consumers to primary care, improving social domains and social determinants of health (e.g., employment, housing), and engaging consumers in alcohol and other substance use treatment programs. Ultimately, the outcome will include multi-agency, multi-health system collaboration in treating the family as a whole rather than the current model of practice in health care. The strategies identified as a part of goal number two will help us to

address the inequities of preventable hospital stays, premature age-adjusted mortality, flu vaccination, and the overarching issues of poverty that the target population experiences.

Strategy 2.1:   Expand the array of community-based support systems in place to guide and support individuals' barriers to access or appropriate use of available services.

Two needs identified in the needs assessment included: 1) Lack of coordination and awareness of health services as well as a lack of education about how to access services that are available among providers and consumers and 2) Challenges in navigating the health care system to receive services. Patients need support in navigating effectively through the care delivery system to receive appropriate care in the appropriate setting. We plan to use existing supportive services that exist in the community rather than starting a new program. We will ensure that all community support staff work effectively together in a coordinated manner to provide a more comprehensive system of supportive care to the targeted population. We will build upon and enhance already existing systems in order to develop a strong foundation and assure appropriate staffing capacity to serve the patients effectively. Processes will be designed to utilize a data-driven approach to identifying patients who need supportive services and to assess and appropriately assign them to one of the resources identified below, including behavioral health support services, care coordination/community health workers, and maternal/child health services. We will use continuous quality improvement processes to assess and evaluate the effectiveness of the processes and redesign them to ensure the patient needs are being met.

Objective 2.1 a: Enhance the current community support services teams in each county to assist patients with *behavioral health needs*.

Participating Partners: Transitions of Western Illinois University, Mental Health Centers of Western Illinois

The activities that will be conducted in order to accomplish this objective include: 1) hire additional community support workers to expand the numbers of individuals they are capable of serving; 6.5 FTE Community support workers will be hired for the two entities 2) use grant funding to expand assertive outreach to individuals in rural parts of the area or those disengaged from services 3) expand the expected role of the community support workers to include whole health integrated care management 4) integrate regular nursing and psychiatric consultation so community support workers have access to expert advice and direction. 5) include in-reach to individuals who are in inpatient psychiatric hospitalization to increase changes for successful engagement in outpatient services.

The fee-for-service nature of Medicaid provides disincentives for behavioral health providers to deliver mental health and substance abuse community-based services to individuals who are located in rural areas requiring extensive travel, reluctant to engage in the registration/ assessment processes initially to establish eligibility for services available in the Medicaid Service taxonomy, and who need care coordination/support for medical issues which are not directly related to their mental health condition (and thus might not meet the medical necessity required for targeted case management). Funding would be used to expand the scope and quality of existing community support programs sponsored by Transitions of Western Illinois (Adams County) and Mental Health Centers of Western Illinois (Hancock, Pike and Brown Counties).

Objective 2.1b: Expand community health workers in the community to help patients effectively access and follow through with appropriate and effective use of *medical services*.

Participating partners: Illini Community Hospital, Blessing Health System, SIU Federally Qualified Health Center

All of the health care partners have established Care Coordination Programs that provide services to patients in the areas of chronic disease management, transitional care management, and embedded behavioral health services. We will expand the capacity of the care coordination programs through hiring community health workers to support the existing staff. This will allow for a cost-effective model to provide needed support for home-based services to the identified patients. Six Community Health Workers will be hired by Illini Community Hospital, and two workers will be embedded in each of the three participating health care entities, including Blessing Health System, Illini Community Hospital, and SIU Federally Qualified Health Center.

The purpose of the proposed objective is to use community health workers partner with the care manager to allow a deeper, more personal, and more trusting connection with the patient. The community health worker's role is to assist in addressing barriers to in accessing or making appropriate use of medical services. The primary goal of the community health worker services will be to create more effective linkages between vulnerable populations and the health care system.   The community health workers will coordinate with the individual's health provider to support individuals by providing coordination of available resources, assistance with enrollment in benefits programs, arranging for transportation assistance, assisting individuals with identification of health-related self- management goals, individual coaching to meet their self-identified health goals, etc. The community health workers will expand outreach to individuals in rural parts of the area or those who disengage from services in locations they already visit. The project will utilize evidence-based Community Health Worker Services as described in the HRSA Community Health Workers Evidence Based Models. As described in the toolbox, CHW programs are designed to improve access to care, increase knowledge, prevent disease, and improve select health outcomes for populations. CHW programs are carefully tailored to meet the unique needs of the community.

Community health workers are a needed addition to existing care coordination programs because individuals residing in rural areas have travel-related barriers to receive services, which can lead to minimal or crisis-driven contact with the health system. This places them at a significant disadvantage for receiving services needed. As a result, this targeted population has a shorter life expectancy and lower quality-of-life expectancy than more advantaged members of the community. The impact upon children and family systems has the potential for multi-generational impact.

Objective 2.1 c : Implement Family Connects Program to improve *Maternal and Child Health Outcomes*

Participating Partners: Adams County Health Department to begin implementation; in future years will add Hancock County Health Department (year two) and Brown County Health Department (year three). Five nurse care managers will be hired to provide services to the targeted area.

Data indicated inequities in the area of low birthweight and teen pregnancy, and it is important to include an intervention targeted to maternal/child health. Family Connects Illinois ensures

that there is an entry point to essential support services for all families in a community – not just those at risk – to receive customized services and support from which they could benefit. Families are identified and engaged in a way that is different from many evidence-based models, which identify and engage only those families who meet certain pre-defined risk criteria. A universal approach, however; is open to all families of newborn children. In addition, the program is not duplicative of other programs, but complements, builds on, and utilizes existing network services. These assessments bring the potential for identifying undetected medical concerns for either the newborn or mother and result in referrals for clinical diagnosis and medical intervention if needed.

The goals of Family Connect Illinois are to enhance maternal and child health and well-being and to reduce rates of child abuse and neglect by connecting all families with community services and resources based on an evidence-based assessment in concert with the families' self-identified interests and needs. FC IL maximizes parental readiness through education, support and resources—partnering with parents to become the parents they dream of being. By serving all families in a community, the program reduces the stigma associated with targeting high-risk populations, generates larger-scale outcomes, and supports community-level change by connecting every family to their community.

Nurses connect with family at the hospital and follow up with one to three home visits. The program consists of a nurse visit(s) to families in their homes at around three weeks following childbirth, where the nurse takes a physical assessment of the newborn and mother, along with psychosocial assessments of the entire family. Shortly thereafter, the nurse reconnects with the family and provides referrals to community services. Examples of Community Resources the program supports include: Health Care Providers, Lactation Support, Household Needs and Material Supports, Community-based Home Visiting, Child Care and Early Childhood Education, Early Intervention Programs, Shelters and Emergency Housing Resources, Behavioral and Mental Health Services, Mother Support Groups, Resources for Siblings, and WIC and Family Case Management.

Implementation activities will include: 1) Hire additional nurses to increase the number of families offered home visits, 2) Collaborate with all OB/GYNS to assign all expecting parents to a Family Case management nurse, 3) Visit every family in the hospital after birth to establish relationships and schedule home visits, 4) Complete one to three home visits with families in the first three months of the baby's life and to connect family to community resources. The Adams County Health Department will collaborate with neighboring health departments to expand the existing program to all families in the surrounding counties.

Objective 2.1 d: Develop care management capacity to identify and provide targeted programming to high-cost patients, patients who are experiencing transitions in care, and those who are high utilizers of the Emergency Department.

Participating Partners: Blessing Health System, Illini Community Hospital, SIU Federally Qualified Health Center

Community data indicate that there are inequities in the area of preventable hospital stays, and it is important to address patients who are high utilizers of services. Three care managers will be hired by Illini Community Hospital and will be embedded within the three

facilities. The care managers will focus specifically on patients who are identified through diagnosis and medical expenditure thresholds in order to assist in reducing cost of care for high-cost patients. The primary foci of this type of case management are rehabilitative, palliative, and catastrophic illness. Patients who are transitioning from one level of care to another (for example, from hospital to home) will also be targeted. Complex case management requires frequent client contact and smaller caseloads than existing care coordination services.

For individuals who are identified as high-cost patients or those leaving hospitalization, the health system care coordination team, supported by the community health workers and community support teams, would work together to identify and secure needed resources within the patient's home community that address their health and behavioral health needs. The care coordination team will work to connect the patient with appropriate resources that are accessible to them from existing providers within the community and ensure the health systems involved are coordinating overall service needs in a collaborative manner.

The goal is to improve population health by engaging identified patients and their family systems related to identifying overall health and wellness needs and gaps in services. The team will engage the family in connecting with existing community services to meet identified needs in a manner that is effective for the patient. This strategy helps manage health system/payer costs by providing care and services to prevent readmissions to both the Emergency Department and hospital and provide services in a lower level of care. The team will ensure communication between medical and behavioral health providers as appropriate to ensure a holistic approach to patient care and preventative care, especially with regard to the social determinants of health.

Emergency department (ED) overutilization costs the U.S. healthcare system nearly $38 billion annually. ED recidivism (defined as ED returns after discharge from an ED visit) by patients ranges between 72 hours 30 days. Many times, ED recidivism suggests other social determinants of health, such as poor health literacy, cognitive impairment, or lack of social support. The priorities for this strategy are identifying the patient needs through care management and ensuring the patients' medical needs are met. Care coordination staff, including community health workers, will be embedded in the ED 24/7 to ensure connections to care that reduce readmission to the hospital and the emergency department. These workers will strengthen connections to community-based services to ensure needs are both identified and met through coordination with the care coordination team and existing providers. The Community Health Workers will be able to make early connections with patients and their families to identify needs and to collaboratively create a plan of care to meet the needs of the patient that could lead to readmission. Community Health workers will proactively provide home visits to the identified ED recidivism patients will decrease the rates of overutilization of the ED.

The Community Health Workers will be able to establish connections and relationships with patients while they are in the Emergency Department and collaboratively create a plan of care related to the identified needs of the patient and their family system, recognizing patients are part of a larger system of supports. This will also allow the identification of gaps in support systems that are able to truly meet the needs of patients upon discharge from the hospital or Emergency Department.

Strategy 2.2   Address social determinants of health barriers faced by the target population

Objective 2.2 a: Increase access to Transportation Services for the target population to help them overcome barriers to receiving care.

Participating Partners: All partners along with contracted transportation company – Integrity Secure Transportation.

Transportation has been identified as a need in the Community Health Needs Assessment. Community leader interviews also identified the need to address transportation issues in the community. 16 percent of workers who commute in their car alone in Adams County commute more than 30 minutes. The farther people commute by vehicle, the higher their blood pressure and body mass index and the less physical activity the individual tends to participate in. Longer commute times have also been associated with poorer mental health. Source: 2021 County Health Rankings (2015-2019).   Survey and interview participants cited access/location and availability/hours of public transportation in Quincy as barriers to securing and maintaining employment and accessing healthcare. Survey and interview participants said the lack of public transportation in rural Adams County leads to economic inequality and isolation. When residents have no way to get to jobs or appointments, they cannot provide for themselves and their families or access the critical services they need.

In order to address the transportation issue, we will contract with Integrity Secure Transportation. Integrity Secure Transportation was formed to help transport special patient populations that need ease of access to appropriate transportation options for their medical care.   Having a local provider dedicated to secure mental health transportation can reduce the headache for individuals needing transportation, increase the likelihood of receiving a bed in a facility with limited bed wait times, overcrowding in facilities, long wait times for the patients, lower employee workload and burnout, and large expenses. Patients in need of the services will be identified from staff at the collaborating agencies. Staff from the collaborating entities will have the ability to schedule transportation for patients online using Integrity's scheduling system. In addition, we will explore options to address the transportation barriers using innovation techniques with the engaged target population.

In addition to working with this contracted transportation company, we will explore additional options to improve transportation services for our area including working with the city bus system to determine if there are easier routes for transportation in the non-rural areas and will innovate on additional potential solutions to transportation challenges and barriers.

Objective 2.2 b: Increase access to Housing

Participating Partners: Transitions of Western Illinois and Quincy YWCA.

Housing was identified as a key target area in the community needs assessment. It was noted that in our community, 10.3% of all incoming families to shelter came from a hospital or substance use treatment facility. In addition, a large lower income housing unit was recently closed in Adams County, leaving over 200 families with no housing. Poverty rates and low median incomes are demonstrated in the target area and also contribute to housing concerns.

Housing is a fundamental need, yet, according to a 2016 analysis of affordable housing, millions of low-income renters cannot afford a place to live. Housing is connected is better health outcomes, economic mobility, employment prospects, and greater opportunities for people exiting the criminal justice system. The lack of affordable, safe, and livable housing in Adams County was a common theme discussed by community stakeholders. Of the 3,230 households

that have been deemed to have severe housing problems, 2,005 are renter-occupied. Severe housing problems include incomplete kitchen or plumbing facilities, more than 1.5 persons per room, and a cost burden greater than 50 percent of family income.

The connections between health and financial stability are well-documented. Financial capability is determined not only by an individual's knowledge, skills, and access, but by the environment in which they live, work, and learn. Through continued collaboration across sectors, breaking down siloes, and putting the voices of those impacted the most at the forefront, we can improve individual financial and physical health while also improving community health overall.

Transitions of Western Illinois is experienced in transitional housing. They will be a contracted partner to provide this service to patients leaving the hospital, substance abuse treatment, mental health treatment, etc. Transitions of Western Illinois will have a housing specialist who is part of their community support team responsible for outreach to individuals with unstable housing during hospitalization, identification and delivery of short-term transitional housing, and assistance with locating permanent housing post-hospitalization. They will also serve as the team's designated outreach worker to homeless individuals to offer behavioral health services. Individuals who are homeless or who have unstable housing often make use of emergency services and inpatient hospitalization to obtain a stable temporary living arrangement. They also are individuals most likely to not be formally connected to traditional systems of behavioral healthcare, as outreach programming isn't supported by the fee-for-service nature of the current system.

The YWCA has a longer-term housing program with limited capacity. We will subcontract with them to expand the program. YWCA Quincy envisions a supportive housing option for those patients served by the collaborative project. YWCA Quincy will lease rental units throughout Quincy and sublease them to supportive housing clients. All rental units must pass the Department of Housing and Urban Development's rigorous Housing Quality Standards and meet rent reasonableness standards and fair market rent. Clients will enter fully furnished rental units and will enjoy all the rights and responsibilities of market-rate renters, with the supports in place to remain stably housed as they recover from their health crisis. To stabilize as many individuals as possible, the program has a maximum stay of two years. After two years, the client may take over the lease from YWCA Quincy, or move into a rental unit of their own. This program is intended to fill a community gap: housing for those with severe health conditions who may have a criminal history that makes them ineligible for other supportive housing programs. Application bonus points will be given to applicants who have low or no income, are Veterans, have experienced domestic violence, are involved with Adams County Mental Health Court, or have previous Blessing Adult Inpatient Behavioral Health stays.

YWCA Quincy proposes 10 rental units in the area surrounding Blessing Hospital and a partnership of five years.

Strategy 2.3 Deploy telehealth strategies in order to increase patients' access to medical services.

The needs assessment and data document that the rurality of the patients combined with low income make it difficult for them to travel to receive healthcare services. Interviews with community leaders

identified telehealth as an effective strategy to help the target population overcome some of the identified barriers to accessing healthcare. Data document the low number of providers in the rural areas and the designation of the areas as shortage areas for professionals. Telehealth services are an effective strategy to bring services to the patients, eliminating their need to travel to obtain healthcare.

The U.S. Department of Health and Human Services, Health Resources and Services Administration defines telehealth as: "the use of electronic information and telecommunication technologies to support and promote long-distance clinical healthcare. Telehealth is helping fill in the workforce shortage gaps and provide services to remote areas. The Blessing Health System has a strong telehealth program foundation, including a well-established project management team and processes, research and data collection abilities, technology, and IT capabilities. The Blessing Health System has been offering telehealth services since 2015 including primary and specialty care visits, as well as direct-to-consumer telehealth services for over a year. The initiatives have been successful in increasing access to care and have been embraced by the providers as an effective method to provide care to patients. The grant funds from the proposed innovation will be used to expand the foundation of services to partners in the collaboration, increasing their ability to serve patients in the remote areas.

Objective 2.3.a: Increase use of telemedicine services to provide telehealth visits for patients for behavioral health and primary/specialty care visits and provider consultations at remote locations in the rural communities.

Participating partners: Initial partners will include Illini Community Hospital, Blessing Health System, and SIU Federally Qualified Health Center. After initial services are established, we can expand to other partner and community sites.

Telemedicine virtual visits offer patients an alternative way to communicate with their doctors regarding health issues. Patients can make an appointment for a virtual visit through the portal or by calling the provider office. Regular monitoring visits will be scheduled based upon the patients' individualized health information. A mobile enterprise patient engagement platform provides the ability for the visits to be implemented. Patients can use any device for the visits. Following the visit, the patient's care summary, treatment plan, health education, and action prompts are all automatically sent to their mobile phone. Telehealth services will include behavioral health and primary and specialty care consultations.

Objective 3.2 b   24/7 access: Increase the use of Care on Demand services in the rural communities to allow convenient, 24/7 access to healthcare where the population resides.

Participating Partners: Blessing Health System

Rural areas historically have had fewer healthcare providers, which results in access issues. Community data document the provider shortage areas and low ration of providers to patients in the area. Interviews with key community leaders indicated that there are not enough providers to meet community needs.

Blessing Health System has developed the foundation to offer Care On Demand services, which use telehealth providers to provide consultations when consumers need them any day, at any hour. Five Kiosk service delivery centers will be provided in the geographic areas that are determined to be the most in need. The Kiosk will provide services to the targeted population where they live, in order to reduce transportation needs. These tools are very effective in serving the extremely remote, rural areas where there is not enough population for a provider

to be present. This delivery model will also assure that patients can access services by going to the location of the Kiosk even if they don't have a mobile device or internet access. The locations will be strategically chosen based upon areas of highest needs and barriers to receiving services.

Objective2. 3.c: Increase the number of patients with chronic disease who have access to Remote Patient Monitoring by expanding the service to collaborating partners and patients who are identified with unmanaged chronic conditions.

Participating partners: Initial partners will include Illini Community Hospital, Blessing Health System, SIU Federally Qualified Health Center. After initial services are established, we can expand to other partner and community sites.

Data presented in the data section document the high numbers of hospitalizations for chronic conditions among the target population. Obesity and chronic conditions were identified as top community priorities in the community needs assessment. Data demonstrate high rates of obesity, inactivity, and inability to access opportunities to be more physically active.

Remote patient monitoring is a subset of telehealth that uses technology tools to track patient data outside of the standard healthcare settings. This type of telehealth seeks to gather patient information from wherever they are and transmit it to clinicians or other healthcare providers. Clinicians have traditionally relied on physical markers, such as weight, blood pressure, and symptoms to manage the care of their patients. These indicators give clinicians little time to respond before hospitalization of a patient becomes necessary, which is critical to patients with uncontrolled chronic conditions. Remote patient monitoring can provide early indicators of a patients' worsening condition, giving the provider actionable data to intervene before a patient has symptoms and needs hospitalization to manage their condition. The ability to monitor care remotely not only enhances quality of care; it improves clinical efficiency and reduces healthcare costs. Remote patient monitoring has been demonstrated to reduce costs, improve access, and increase positive health outcomes, particularly in chronically ill patients (MHealth Intelligence).

Participating patients will receive a connected health kit which includes a Bluetooth-enabled tablet with peripheral equipment including thermometers, wrist blood pressure cuff device, a Bluetooth body weight scale and Bluetooth pulse oximeter. The devices are already paired and require very simple assembly to connect. The patient turns on the tablet, plugs in the devices, and the monitoring system is ready to use. A welcome call is provided which helps the patients get started using the technology. The technology is very easy to use; elderly patients who have not used any technology before, have been using the kit with great success.

A patient schedule is set up which issues reminders for readings and medications as well as target values for vital signs and weight.   A patient's heart rate, blood pressure, and cardiac anomalies can be monitored in real time using these devices. When a reading exceeds limits created by the care team, an email is sent to the Patient Coordinator. Patients can log in to see their client dashboard and see how they are doing against their targets, and to see trends in their data. The provider team has access to a comprehensive clinician dashboard and portal which provides access to patient vital sign data 24 hours a day, 7 days a week. Clinicians can monitor the vital signs from almost anywhere and look for patterns that might suggest a patient is getting worse. By monitoring the patients closely, the care team can intervene early to

change behavior, adjust medications, send a home-care nurse, make a house call, or perform any other needed interventions.

- The benefits of using remote patient monitoring to improve quality of care are numerous: better care
- less travel
- fewer doctor's visits
- care teams can see patients' vitals in real time and better recommend treatment options
- care teams can intervene early to change behavior, adjust medications or perform any other needed intervention
- fewer emergency room visits
- fewer hospital admissions
- ability to live at home longer
- patients have an increased feeling of being in more control of their health
- patients have confidence in knowing clinicians are monitoring for any issues before they become emergencies
- reduced anxiety and increased confidence in treatment for patients
- caregivers and family can be provided access to patient information, keeping them up to date with the patient's condition.

The proposed program will expand the initiative to include provider partners and new patients identified through collaborating entities who have uncontrolled chronic disease.

Participating Partners: Illini Community Hospital, Blessing Health System, SIU Federally Qualified Health Center, Transitions of Western Illinois, Adams County Health Department, Counseling Center of Western Illinois

Objective 2.3d Implement a technology-enabled mental wellness service to engage patient behavioral health in a rural setting.

The community needs assessment documented that mental health is a concern for the target population. Data demonstrate that the population experiences high number of mentally unhealthy days, frequent mental distress, and high rates of Emergency Department visits for behavioral health conditions.

To help patients overcome access-to-care barriers in the remote locations, a behavioral telehealth system will be implemented. The system will continuously assess and engage patient mental wellness in a remote setting. Providers will use the technology to administer remote assessments and screenings, push relevant content to patients, and risk-stratify their patient population so they deploy a higher level of care to address those with the most pressing behavioral health needs - before a crisis occurs. By integrating behavioral health into primary care and beyond, the partners will be able to continuously monitor patient wellness and deploy efficient and effective remote solutions. In rural and low-income settings, behavioral health has gone largely unaddressed. And in the wake of the COVID-19 pandemic, a transition to remote care has exacerbated the problem. As a result, compounding behavioral and physical health issues are creating a collective barrier to recovery for patients. Through use of the system, we

will be able to remotely measure the impact of providing mental wellness resources and compare how addressing behavioral health affects outcomes across all patient populations.

Strategy 2.4 Implement strategies to address identified gaps in the existing service delivery of care and enhance the ability of the existing workforce to deliver services

Objective 2.4 a: Increase Access to Dental Health Services

Participating Partners: SIU Federally Qualified Health Center

Dental care is an important part of basic health care. There are many factors that cause access to dental care to be an issue within communities – including economics, age, cultural and racial background, and access to transportation. Lack of dental coverage, access, and out-of-pocket costs limit the ability of many residents to obtain proper and consistent dental care. Data have demonstrated that patients in the area have issues accessing dental services due to lack of providers and lack of providers who serve the Medicaid population. The SIU Federally Qualified Health Center has a dental clinic that provides services to the underserved population but has had challenges with 1) recruiting a dentist to the facility and 2) financially sustaining the clinic based upon fee-for-service rates. The clinic has space for three dentists, and currently only has one on staff. There is a five-month waiting list in order to receive a dental appointment at the Dental Clinic. The proposed innovation contains budget items to incentivize a dentist to work at the clinic, including a sign-on bonus and additional bonus pay to make the salary competitive, increasing the ability to staff the dental clinic.

Objective 2.4b: Increase access to primary and specialty care through the use of a mobile health unit to provide medical care to the highly remote, rural communities in the service area.

Participating Partners: Illini Community Hospital, Blessing Health System, SIU Federally Qualified Health Center, Transitions of Western Illinois, Adams County Health Department, Counseling Center of Western Illinois

Community leaders identified mobile services as an effective strategy to increase access to healthcare services for the target population. Growing bodies of literature support the fact that mobile clinics are a successful, innovative, and cost-effective model of healthcare delivery. Mobile units are uniquely positioned to assess and fulfill the needs of the underserved rural patients who have transportation challenges. Through the act of driving directly into communities and opening the doors on the steps of the patients, mobile clinics have been shown to be able to engage and gain the trust of vulnerable populations. Because mobile clinics can overcome many health barriers and social determinants of health services, they have been shown effective in improving individual health outcomes, advancing population health, and reducing costs compared to traditional clinic settings. Mobile clinics can play an important role in our evolving healthcare system. The mobile unit will be used to provide primary and specialty care in the most remote areas of our target region.

Objective 2.4 c Increase the psychiatry capacity by implementing a telehealth services agreement with a contractor.

Participating partner: All collaborating partners

The targeted communities have a lack of psychiatrists to provide services throughout the area. There is currently an average of 41.5 days from date scheduled to an available appointment date for psychiatrists. Some of the psychiatrists are scheduled out as far as 183 days. Blessing Health System has a majority of the psychiatry capacity and contracts their services to various entities in the area in an attempt to meet the psychiatric needs of the community. In order to increase capacity to effectively provide behavioral health services, we will contract with a licensed contractor to provide licensed healthcare clinicians to deliver behavioral health services including psychiatry via telehealth using real-time technologies.

Objective 2.4 d Enhance the hours of the pharmacy program at Illini Community Hospital in order to provide prescription medications to patients being discharged from the Emergency Department after normal working hours.

Meds to Beds programs have been shown to significantly reduce 30-day hospital readmissions and emergency department visits. Hospitals also report that these programs increase the number of patients actually obtaining their discharge medications by removing common barriers related to payment and transportation, increasing patient satisfaction, and reducing costs. Meds to Beds program, (Home Rx) is a current retail pharmacy inside Illini Community Hospital that provides a 1 to 14 day supply of new prescription medications to discharged patients. Current hours of operation are 7-3:30pm Monday-Friday. A pharmacy tech will be hired to work 3-11 pm to address a majority of the Emergency Department patient concerns.

Objective 2.5e Increase the number of children who receive community-based services for behavioral health.

Participating Partners: Transitions of Western Illinois, Counseling Center of Western Illinois

This objective will enhance children's community-based service capacity by completing two main activities. The first is to expand or create school-linked therapy services. Secondly, we will expand access to community support services in each county. Children who do not receive adequate community-based mental health services are at risk for avoidable or repeated psychiatric hospitalization. Access to community-based services can both meet the needs of children serviced and reduce costs. Two therapists will be hired to deliver the services for this objective.

3. Governance Structure

We recommend you consult the HFS Guide to Collaborations for your reference as you develop your governance structure. The governance section should reflect serious thought regarding the execution, management, accountability, and interreliance of the participating members of your collaboration. It should be clear how the structure and governance will bind the various participating organizations into an interrelated enterprise to accomplish the scope of work and the promised outcomes of the proposal. A well-developed governance process is the engine that will drive the effective implementation of the project. Absent quality governance, great ideas and good intentions often fall short or fail altogether Structure and Processes

1. Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set?

<u>Membership:</u> Members of the collaborative have been successfully working together to implement a variety of successful community initiatives. The membership is a diverse group representing entities that provide healthcare services as well as providers of social services. Collaborating entities include a critical access hospital, healthcare system, United Way which works to united various social service entities, Federally Qualified HealthCare System, Health Departments and Mental Health entities. The diverse nature of the collaborative members will support the comprehensive nature of the proposed project. All members of the collaborative have contributed equally to the development of the proposed project and are committed to the successful execution of their identified role in the collaborative activities that are needed to truly transform the healthcare delivery system.

<u>Authority and responsibility of participants:</u> A governing body of two leaders from each of the participating entities will be developed in order to guide the proposed program. In addition, two at-large community members will also be members of the governing board. The governing body will have regularly scheduled meeting on a monthly basis. Meetings will be scheduled more often if the need arises. Responsibilities of the governance committee will include: strategic planning, oversight of the program including continuous quality improvement processes implementation and evaluation, fiscal oversight, and community engagement

The governing body will utilize Robert's Rules of Order to govern procedure at all meetings. If consensus is not able to be reached, decisions will be made by a majority vote of the network members following discussion. Continuous quality improvement will be used to evaluate and make adjustments to the project management of the program.   In order to address urgent or emergency situations, network procedures will allow for special meetings to be called at the request of any governing body members. The procedures will also allow for a written ballot to approve action to be taken in place of an in person meeting if consent is signed by the consortium members. Issues that may arise in the consortium include absence from meetings, lack of engagement and lack of agreement of direction for the project. In addition to communicating at the monthly meetings, project update reports will be given as needed based upon the level of activity in between the scheduled meetings. Email will be used to communicate with members as well as to update them regarding a situation and to receive their input. An annual meeting of members will be held to provide an update regarding the project status, evaluation results, etc.

[1. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Accountability 2. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence? [2. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Memorandum of Agreement letters will identify responsibilities and will be signed by appropriate leadership of the participants. These agreements will assist in holding participants accountable for all project deliverables.   The agreement will define the authority and responsibility of participants in completing the project and proposed outcomes; agreement to adhere to collaborative policies; statement of agreement to act in good faith regarding the collaborative. The agreement will also specify the scope of participation for each entity including: staffing commitment; title and job description of employees assigned to the collaborative; staff hourly commitment to project implementation; budget resources received by the entity; in-kind resource commitment; evidence of authority to participate in the project as well as confirmation that all necessary organizational policies are in place including non-discrimination, sexual harassment, diversity, training, ethics, and requirements regarding record keeping and reporting.

The agreement will include assurances that Illini Community Hospital, the lead entity for the proposed project, will serve as the fiscal agent. By serving as the fiscal agent, Illini Community Hospital affirms that the necessary internal fiscal integrity measures and safeguards are in place that assures the funds will be distributed and used for the collaboratives' proposed intended purpose. In addition, a statement of the fund distribution policy and procedures will be included in the agreement as well as a statement that funds will be distributed in a timely manner.

New Legal Entity 3. Will a new umbrella legal entity be created as a result of your collaboration? Yes No 3A. Please give details on the new entity's Board of Directors, including its racial and ethnic make-up. Page 11 of 32 Healthcare Transformation Collaboratives for Reference Only [3A. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

No- a new umbrella legal entity will not be created as a result of the collaboration. The project will be implemented utilizing existing infrastructure.

4. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify

Illini Community Hospital will exercise administrative and programmatic direction over grant-funded activities, with strong involvement of consortia partners. Illini Community Hospital has the financial and accounting management systems in place to successfully implement the proposed program utilizing our fiscal department for this function. Illini Community Hospital has successfully administered numerous grants over the past fifty years. Illini Community Hospital has financial statement accounts designated specifically for the tracking of grant money. When grant money is received, it is allocated to a specific account. There is a process in place to handle disbursements from these funds, which requires approval that the funds are being used for their intended purposes. The financial statements and internal processes are audited annually by independent auditors.   The accountants are responsible for reconciling grant funds; the minimum education requirement for accountants hired in the fiscal department at Blessing Hospital is a bachelor's degree in Accounting and all participate in continuing accounting education in various forms.

4. Racial Equity

A fundamental focus of healthcare transformation is racial equity. Please provide a high-level description of how the design of your proposal incorporates racial equity. (Greater detail will be requested in the questions below.) [High Level Narrative - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.) Racial Equity Impact Assessment Questions 1. Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal? [1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

The first goal of the proposed innovation is to develop an engagement strategy to address inequities – including racial – in the existing service delivery system and to addresses the social determinants of health barriers that result in disparities in individuals' ability to access care. The objectives include measurement and research to identify inequities including racial, partnership with diverse groups to identify potential strategies, and policy and process development to address the identified inequities. All of these activities incorporate racial equity identification and creation of strategies to address the identified areas.

2. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved, and authentically represented in the development of this proposal? Who's missing and how can they be engaged? [2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Stakeholders from different racial/ethnic groups have been informed, meaningfully involved, and authentically represented in the development of this proposal. Stakeholders were involved in developing the proposed innovation through meetings and discussions about the proposal, key informant interviews, involvement in the community assessment process and involvement in the compression planning process. We will continue to involve more groups and individuals from different racial/ethnic groups through the proposed intervention. One of the main goals of the proposed intervention is to utilize an expert consultant to assist us to change the way we engage the groups to a partnership and much deeper, meaningful involvement.

3. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed? [3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

We have identified initial areas of disparity that negatively impact the black and Asian population as compared to the white population. Identified areas of disparity include the areas of low birth rate, premature death, teen birth rate, preventable hospital stays, percentage of child population who live in poverty, homicide rate, rate of flu vaccination, and median household income. Through the proposed project we seek to increase the amount of data that we have to identify the disparities that exist in our community.

4. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it? [4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

There are many complex systemic factors that have produced and continue to perpetuate racial inequities. The inequities arose from generations of compounding factors that have led to the inequitable conditions that exist today. In order to address the issues, our innovation will work with those impacted to identify and address the root causes.

5. **What does the proposal seek to accomplish? Will it reduce disparities or discrimination? [5 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)**

The proposal seeks to create strong organizational partnerships with diverse stakeholders representing patients, families, and community partners can help the collaborative take actions toward improving the coordination and equitable delivery of high-quality, safe health care.   We will collaborate with identified partners to address disparities in care quality and safety. Effective and sustainable partnerships will be created by intentionally including as many diverse partners as possible, acknowledging their perspectives and values, establishing clear and consistent communication, and demonstrating willingness to tackle issues collaboratively. Finally, we will activate and mobilize a network of diverse stakeholders to educate and inform the community on key areas of focus for impact including but not limited to health disparities in diseases and chronic conditions such as heart disease and diabetes. Our educational interventions will be designed to increased access to primary and specialty care while removing barriers such as insurance, transportation, and care navigation.

6. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized? [6 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

The positive impacts and opportunities will be the redesign of care, policy, and processes based upon the feedback of the targeted groups in order to meet identified needs better. An Integrated Patient Family Engagement Assessment will be conducted to identify changes that are necessary, and community, patient, and family partners will be consulted to help identify low- or no-cost alternative methods for addressing barriers. We will make tangible changes that improve care experiences for patients, particularly those from vulnerable populations. There is a potential for people to be left out or felt that they are not heard or valued. In order to assist us to address this potential risk, we are contracting with an experienced consultant who will replicate a model that has been proven to be successful in many other communities. Together as a community we will work to obtain an unprecedented engagement to redesign our system of care and address the racial and ethnic inequalities that exist today.

7. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion? [7 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

We believe that our approach to addressing racial disparities and advancing racial equity is a well-designed and will successfully engage the community leaders to help address the issues. The experience of the consultant who specializes in this area will be used to guide us to a successful outcome.

8. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability? [8 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

The proposal is realistic, and the budget contains adequate funding to ensure successful implementation. Provisions are included to ensure ongoing data collection, reporting and stakeholder accountability.

9. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed? [9 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

There is an identified performance strategy and accompanying objectives to measure progress in the proposed innovation. A performance improvement management system will be established to collect and assess data about the patients and families served by the collaborative, disparities in care quality and safety among them, social issues affecting the surrounding communities, and the collaborative's workforce and resource capacity. A data architecture framework using quantitative and qualitative measures for regular reporting will be designed. The framework will include SDOH data and other equity metrics i.e., REaL data. An Equity Scorecard will be customized to the collaborative and leaders will be trained on the use of the tool for ongoing performance management. Data will be collected, and quality and safety performance indicators will be examined, as well as PFE measures, by demographic and socioeconomic subgroups of patients. We will systematize stakeholder engagement activities to collect qualitative data in support of understanding patient and community experiences and needs. The community health needs assessment will be utilized to identify the most pressing social determinants of health for the community and link them to impacts on health and health care.

5. Community Input

1. Describe the process you have followed to seek input from your community and what community needs it highlighted. 2. Please upload any documentation of your community input process or findings here. (Note: if you wish to include multiple files, you must combine them into a single document.)

We used three primary strategies for collecting input from community members including the Community Health Needs Assessment process (CHNA), Community Health planning including a

compression planning session, and one-on- one interviews with key government officials as well as with community leaders and stakeholders.

Community Health Needs Assessment

In 2001, United Way of Adams County, University of Illinois Extension, and Adams County Health Department joined together to conduct a Community Assessment for Adams County, Illinois. With the enactment of the Patient Protection and Affordable Care Act (PPACA) in 2010, Blessing Health System joined the collaboration, taking an active role in the community building effort. In 2021, the United Way of Adams County applied for and received an R3 – Restore. Reinvest. Renew. Assessment and Planning Grant from the Illinois Criminal Justice Information Authority. The purpose of the Assessment and Planning grant is to support community organizations to assess community needs and develop a plan for delivery of economic development, violence prevention, re-entry, youth development, and civil legal aid services. This Adams County Community Assessment is the first step in developing a plan to address community concerns and needs. The process for the Adams County Community Assessment includes the collection and analysis of primary and secondary data. Both public and private organizations including government agencies, faith-based organizations, educational systems, nonprofits, and health and human service entities, as well as the general public, contributed to the process and data.

The Community Needs Assessment was conducted in 2021. The survey instrument was overhauled and an effort was launched to get a more diverse representation of the community. We were able to secure feedback from 861 respondents via two survey instruments. Respondents from the surveys were 93 percent white or Caucasian, 55 percent female, and the ratio of Quincy to rural Adams County residents was around 80/20. These demographics generally match the demographics of the Adams county region. Included in the survey results were the results of in-depth interviews with 33 key stakeholders on the front lines of community health and social service. These informed stakeholders shared candidly their challenges, and opportunities they see for growth. While responses varied, one overwhelming theme throughout all of the interviews was **an *innate hope and optimism*** by practitioners in direct service of our community in areas such as social services, health, education and safety.

The top challenges/concerns our community is facing in the realm of community health include:
• Mental Health: Mental health issues have significant impacts on people, families, communities, and societies. There are many factors linked to mental health, including genetics, age, income, education, employment, and environmental conditions.
• Substance Abuse Addiction is a chronic, but treatable, brain disorder. People who are addicted cannot control their need for alcohol or other drugs, even in the face of negative health, social or legal consequences
• Education: Social and economic factors such as income, education, employment, and social supports can significantly affect how well and how long we live. Educational attainment in particular is a strong predictor for future health outcomes.
• Chronic Disease: Diabetes and Heart Disease: Chronic diseases can be managed, and many are preventable. However, generational attitudes along with the ability
to obtain necessary health care services need to be addressed in order to allow community residents the opportunity to live a healthier life. Education, information, and improved access can have a significant impact in reducing the chronic conditions of residents.
• Poverty: poverty is linked with negative conditions such as substandard housing, homelessness,

inadequate nutrition and food insecurity, and under-resourced schools. Poor children and teens are at greater risk for several negative outcomes such as poor academic achievement, school dropout, abuse and neglect, behavioral and socioemotional problems, physical health problems, and developmental delays.

Mental Health
Depression, Anxiety, Stigma, Access to Services, Impact of COVID

Obesity
Access to Healthy Foods, Lack of Exercise/Physical Activity, Economic Insecurity, Lack of Nutritional Education

Substance Abuse
Addiction, Economic Insecurity, Trauma, Violence, Generational Issues, Access to Services

Housing
Safety, Affordability, Access, Substandard Conditions, Poverty

Diabetes, Heart Disease
Chronic Health Conditions, Physical Inactivity, Aging Population, Lack of Healthy Food Options

The assessment highlighted some important strengths Adams County should continue to leverage and build upon, including: Social Service Agencies, Parks and Trails, Public and Private School Systems, Ongoing Collaboration, Planning, and Development Efforts, and the Regional Healthcare Hub.

Social Service Agencies
Horizons, YMCA, Salvation Army, United Way Nonprofits, Community, Services

Parks/Trails
Quincy Park District, Klingner Trail, Programs, Activities, Riverfront

School Systems
Community Health Workers, Education, Services, Free Lunches, School-Based Programs

Collaboration
Community Initiatives, Planning, Compassionate, Nonprofits, Outreach Efforts, Networks

Healthcare
Access, Blessiny Health System, SIU Family Medicine, Quincy Medical Group, Outreach, Services, Education

Social Determinants of Health (SDOH) is defined by the U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality of life outcomes and risks. Adams County survey respondents identified the following SDOH as one of their three most critical issues facing Adams County residents:

• Economic Insecurity
• Lack of access to healthy foods/lack of nutritional education
• Lack of safe, affordable housing
• Poverty
• Aging Infrastructure
• Inequality
• Transportation

Community Health Planning- Compression Planning

The compression planning session was designed to focus energy on the community priorities. It is an effective tool for securing stakeholder buy-in, reducing emotionality around decision making, and establishing priorities for new initiatives. The session identified barriers, key performance indicators and key players for the three priorities of behavioral health, poverty, and transportation.   This information is used to develop action plans for the key areas.   The compression planning session was held on October 22, 2021, with over fifty participants. The participants represented a variety of populations from the segments including social service agencies, community mental health providers, medical providers,

education, consumers, local foundations, food pantry, churches, businesses, childcare, workforce, city, and local neighborhood groups.

In addition to gathering information for action planning, the compression session was utilized to obtain feedback regarding the proposed program. Three questions were asked and included: "How can we improve access to care with a specific emphasis on equity and inclusion?", "How can we help Medicaid patients overcome social barriers such as transportation and poverty that limit them from accessing healthcare and other services?", and "How do we provide physical, behavioral and social care in an integrated and coordinated way?"   Following is a summary of the input that was obtained:

How can we improve access to care with a specific emphasis on equity and inclusion？ Respondents indicated that we need to focus on making it easy for the population to obtain services- be where the need is, take care of people where they are, offer assistance with childcare and especially for those who work second and third shift and increase transportation options. It is important to consolidate service options to limit going place to place.   It was also noted that we must reduce issues to reach someone for help- difficulty with phone calls, having the right paperwork, multiple handoffs, identification of services and where they are located as well as multiple stops to get to the end point. Another theme of the feedback is to have the right messenger to those receiving the services, use people the population and relate to and connect to and those that will have empathy for those seeking services. It was noted that it is important to train people who have been through similar situations such as a peer specialist and using the target population to be involved in the solution options. It was also emphasized that it is important to build relationships, build trust and establish a god point of contact. We must involve the target audience in developing the solution options. Finally it was noted that it is important to provide education and break down the stigma of getting help- use an open approach to assist with mental, physical and spiritual aspects of need.

How can we help Medicaid patients overcome social barriers such as transportation and poverty that limit them from accessing healthcare and other services? Respondents indicated that using mobile options to remove barriers and get services closer to the clients would be beneficial and using on-demand tele services to include physical and behavioral health services to improve access is an option to help reduce barriers. It was also noted that in addition to offering telehealth services, we need to provide assistance to make sure that people are able to effectively utilize the telehealth services. Another point was to make sure there are mobile translation services that are digital and available and making sure that brochures and websites are in other languages. It was also noted that poverty can lead to a person not being able to access medications, follow up testing, copayments that are needed. We need to make sure there are enough programs that are easy to access to meet the needs of the patients. It was noted that our community is implementing IRIS, an information and referral system, and the use of this system can help connect people to needed services.

Various options were mentioned to assist with transportation needs, including: getting transportation information out to organizations, use services similar to LYFT, provide a community van or free bus passes, address timing that buses run, making sure there are more effective transportation services for patients with disabilities, having buses run past 6 pm, and addressing the number of stops to get to a certain location with the existing bus route. It was noted that the more remote communities have fewer options and more challenges to obtaining transportation.

It was also noted that patients need extra assistance in navigating the system. Suggestions to address this included having caseworkers to help patients on a one-to-one basis, limiting paperwork for patients as it is hard to understand and the language can be tricky, having integrated intake as an initial entrance point for healthcare services and having someone to meet patients at the door to help them find where they need to go- use a greeter to show them. It was noted that it will be important to address the stigma of Medicaid and to overcome this as well as trust issues for the population.

How do we provide physical, behavioral, and social care in an integrated and coordinated way?
Respondents noted that it is important to use a holistic approach to health care and to have many services either in one location or in close proximity. We must redefine the definition of health and how to care for people. Care must be delivered on a continuum of care basis possibly with an umbrella organization to point people in the right direction. Consider having health workers who work with the entire family. Healthcare must encompass multiple aspects that play into the health of an individual and community. It was also noted that we need to have a coordinated, community approach to what services we can provide. There are services available, and we need to have a coordinated, team approach. We need to partner with different partners. Duplication must be avoided. We must assure that everyone has the same level of services.

<u>One-on-one Interviews</u>

Team members conducted one-on-one interviews with government officials as well as community leaders and stakeholders. Discussions with leaders centered around four areas: how the needs of Medicaid population are currently accommodated, perceptions of how the healthcare system works for the target population, barriers to appropriate use of system and ideas on how to increase appropriate access. Following is a discussion of each area and the insight that was gained:

How the needs of the Medicaid population are currently accommodated: Respondents noted that there is a disproportionate number of children on free/reduced lunch and so Medicaid is important to healthcare in our area. It was also noted that the population tends to make more use of emergency services and hospitalizations for preventable issues.

Perceptions of how the healthcare system works for the target population: Respondents noted that the system works well for basic healthcare – immediate needs – for the ability to see a doctor or access hospitalization if needed. It is believed that the system breaks down for people with behavioral health problems. There is more demand for services than there is capacity at times. Efforts have been made to make more preventive services available, they still do not meet the needs. It was noted that there is some distrust/discomfort in going to healthcare providers on the part of residents in the northwest and southwest areas of Quincy – "'Will I be treated with respect?' and 'Will I be heard?' are concerns. Another interesting perception was noted that healthcare may not be as important to the Medicaid population as it is to us as providers. Many on Medicaid grew up in families who received Medicaid and in families where preventive care was not emphasized … 'you get medical attention when you are sick or in pain … and then you go to the ER.'"

Barriers to appropriate use of the system: Respondents noted that there is a lack of sufficient number of trained professionals to meet the mental health needs of the population. Most requested more mental health services – both youth and adults believed there was a need for more mental health services.

Emergency services are overused and possibly abused. Police are regularly involved more than desirable in helping people in mental health crisis. Drug use is a problem that is interrelated to mental health issues, homelessness and use of emergency services. Access to housing remains a problem for some segments of the population. Transportation is a barrier that must be addressed as well. It was also noted that there is a lack of access to care at the appropriate level leading to additional emergency department visits and overburdening the patient load at this level of care.

Ideas on how to increase appropriate access: Respondents indicated a need to increase the number of mental health professionals in the area. In addition, it was mentioned that it is important to create alternatives to use of emergency care for preventable issues. Care coordination, especially for patients with mental illness was noted as a way to increase access to services. Also noted was a need for home post-natal care to assess and supply the needs of families with newborns. Leaders also noted that support training for those who work in mental health is a need to assist families in accessing care more effectively. Respondents indicated that personal relationships with providers are critical in developing trust in service providers and in feeling comfortable accessing services.

One respondent indicated that he believed the focus on gathering information from the target population regarding what they see as barriers to accessing services and what could improve access to and outcomes of healthcare services was very much needed. One respondent who is community leader who grew up in public housing in our community stated "we, as providers, think we know what people want/need, but we do not ask the populations we plan to serve what they want/need. Planning by looking through the lens of those to be served is critical in transforming the healthcare system."

The following persons provided on-to-one interviews as well as letters of support for the proposed program.

Name	Entity	Position
Mike Troup	City of Quincy	Mayor
Jill Tracy	State Senate Illinois 47th District	Senator
Cheryl Williams	Bella Ease	Executive Director
Jerry Gille	Quincy Housing Authority	Executive Director
Gary Mendenhall	City of Pittsfield	Mayor
Steve McClure	State Senate Illinois 50th District	Senator
Kent Schnieder	Adams County Board	Chairman
Chris Bruns	Pike County Unmet Needs	President
Betty Coonrod	Brown County Health Department	Administrator
Mike Boley	Nauvoo Police Department	Chief of Police
Rodney G. Clark	Ninth Judicial Circuit Court	Circuit Judge
Caitlin Willey	Hancock County Probation Dept.	Probation Officer

6. Data Support

Note on the importance of data in proposal design: It is imperative that applicants use data to design the proposed work. HFS is seeking applications that are "data-first." This means that applicants used data to determine health needs and designed and targeted the proposed work to meet those needs. Examples of relevant data include, but are not limited to, data from the community data reports produced by UIC, data analysis of healthcare utilization data, qualitative and quantitative surveys, literary reviews, etc.

1. Describe the data used to design your proposal and the methodology of collection.

Data from the Community Needs Assessment was reviewed to provide data on which to design the proposed innovation. Secondary data collected in the assessment includes demographic, physical health, mental health, social, and economic information available from local, county, state, and federal primary sources. The secondary data profile allows us to look at health and social issues on a broader scale and in a larger context including health indicators on a local, state, and national level, data trends and comparisons among county, state, and national data. The data will be presented in the categories of the six priorities that are addressed through this innovation including: behavioral health and substance abuse, access to care- including chronic disease, care coordination social determinants of health, workforce and maternal/child health.

In addition to the secondary data, the primary data collected through the community needs assessment, compression session as well as one-on-one interviews with stakeholders and elected officials was invaluable in assisting in the development of the proposed intervention. The community needs assessment data included responses from 861 community members in the form of survey responses. The compression session included information from fifty participants and included four questions identified previously to obtain input regarding the proposed innovation structure. The one-on-one interviews consisted of four questions as well as open discussion with ten community leaders and elected officials to obtain their input regarding the current system and opportunities to redesign the system.

2. Attach the results of the data analyses used to design the project and any other relevant documentation. (Note: if you wish to include multiple files, you must combine them into a single document.)

There are many barriers that need to be overcome in the targeted area that result in challenges for the population in accessing care. Some of the barriers include: lack of providers in the area, mileage that is required for the population to travel to receive services, poverty, and lack of insurance. These areas are discussed in more detail below.

Rural areas historically have less health care providers which results in access issues. The Department of Health and Human Services, Health Resource and Services identifies Health Professional Shortage Areas (HPSA) as geographic area or populations within geographic areas that lack sufficient health care

providers to meet the healthcare needs of the area or population. HPSA's identify areas of greater need throughout the United States so that limited resources can be targeted to these areas. The HPSA designation applies to primary care, dental care and mental health.   All of the targeted communities are identified as medical HPSAs documenting the need for healthcare in those areas.

MUAs and MUPs identify geographic areas and populations with a lack of primary care services. These designations are also by the Department of Health Services, Health Resources and Services. All counties have the entire population or portions of the counties as Medically Underserved Areas (MUP) documenting the need for primary care services in these areas.

The following chart identifies these designations for the targeted counties:

LOCATION	PCP HPSA	Dental HPSA	Mental Health HPSA	MUA/MUP
Adams	PCP HPSA	x	x	-
Pike	PCP HPSA	x	x	MUA- entire County
Brown	HPSA	x	x	MUA- entire County
Hancock	HPSA	x	x	MUA- entire County

The following chart shows the number of residents per primary care providers. Most all of the targeted counties except Adams have significantly lower numbers of providers than the state and the top US performers. Brown has significantly less providers than the state and other top US performers, as does Hancock.

Ratio of Primary Care Providers			
COUNTY	RATIO	STATE RATIO	TOP US PERFORMERS
Adams	1:380		
Pike	1:1200	1:240	1:1,030
Hancock	1: 4460		
Brown	1:6560		

Source: Illinois Health Rankings, 2021

The following chart depicts the ratio of residents per mental health providers. Hancock County has significantly lower numbers of mental health providers than the state and other top US performers :

Ratio of Mental Health Providers			
COUNTY	RATIO	STATE RATIO	TOP US PERFORMERS
Adams	1:360		
Pike	1:110	1:410	1:270
Hancock	1:630		

Brown	1:310	

The chart below demonstrates the mileage from the targeted communities to Quincy, IL in Adams County which is the largest healthcare medical hub in the areas. The need to travel is a significant barrier to the population, especially when combined with high poverty levels of the residents. Residents in the service area need to travel an average of 87 miles round trip to receive care in Quincy.
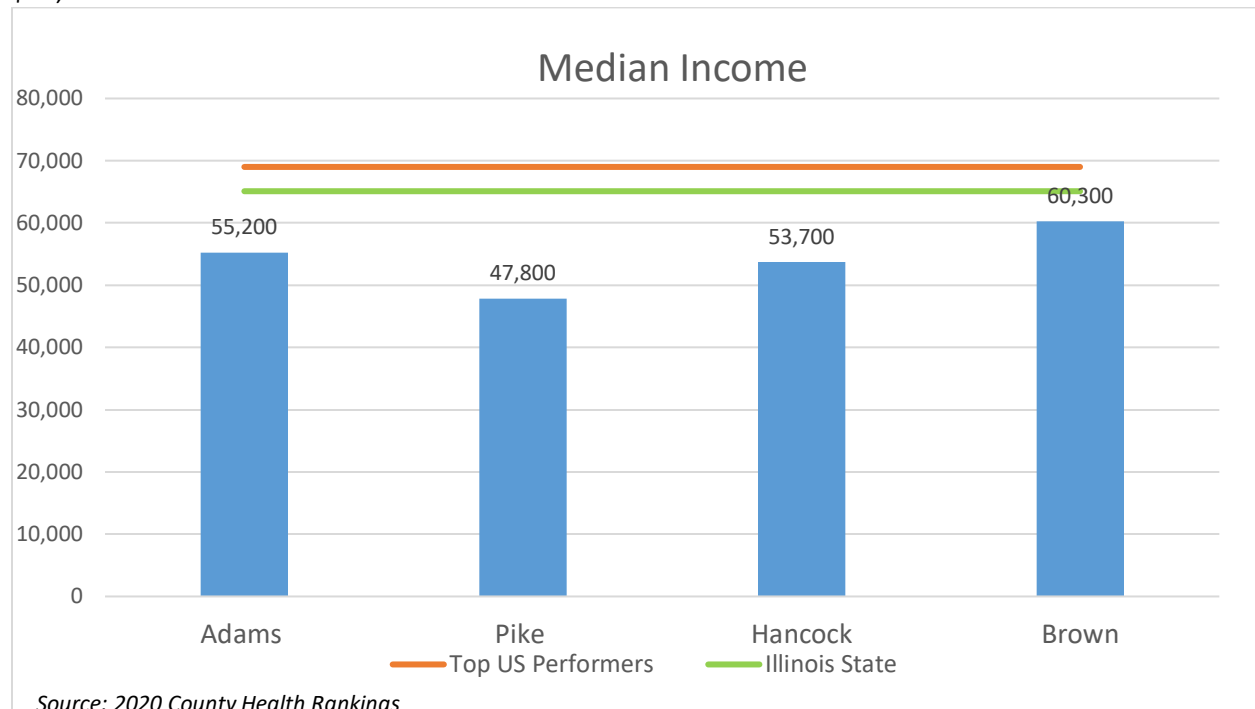
County	Miles traveled to Quincy (Adams County)
Adams	-
Pike	100
Hancock	80
Brown	81

Poverty is considered a key driver of health status and creates barriers for patients to receive access to healthcare services. The following chart documents that all five of the counties have significantly higher poverty rates than that of the State and of the top US performers. The State of Illinois has 11.5% of the population that lives in poverty- Pike County has a poverty rate 2.6 percentage points higher than Illinois while Adams County is .8 percentage points higher. The top US performers have a poverty rate of 10.5%:

Source: U.S. Census Bureau
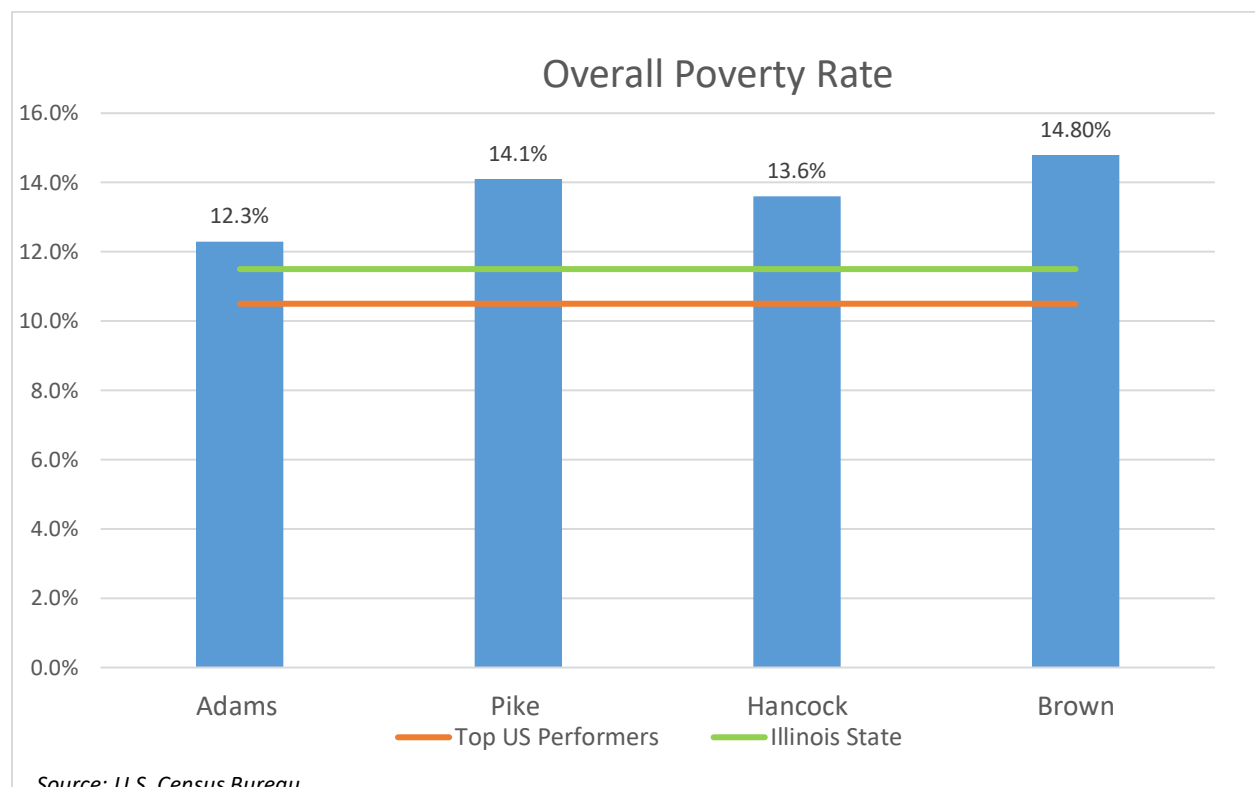
The median income for all of the counties is well below that of the state which is $65,100 in Illinois. All are also considerably lower than the top-performing U.S. counties of $69,000 as shown in the graph

below. The median income level for Adam County residents is $55,200 ($9,900 lower than Illinois), Pike County is $47,800 (which is $17,300 lower than Illinois), Hancock County is $53,700, and Brown is $60,300.


Median Income

	Adams	Pike	Hancock	Brown
Value	55,200	47,800	53,700	60,300

— Top US Performers   — Illinois State

Source: 2020 County Health Rankings

The top community health challenges/concerns we are facing, as identified in the community health needs assessment, include:
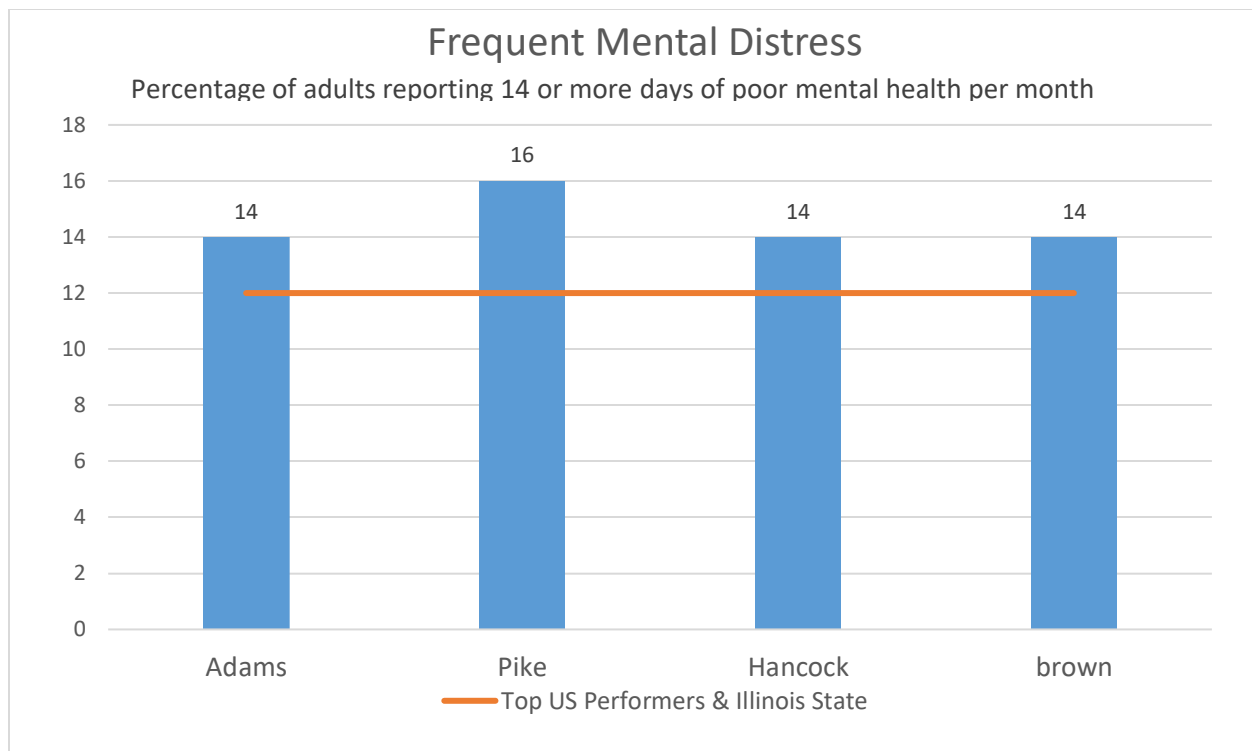
• Mental Health: Mental health issues have significant impacts on people, families, communities, and societies. There are many factors linked to mental health, including genetics, age, income, education, employment, and environmental conditions.
• Substance Abuse Addiction is a chronic, but treatable, brain disorder. People who are addicted cannot control their need for alcohol or other drugs, even in the face of negative health, social or legal consequences
• Education: Social and economic factors such as income, education, employment, and social supports can significantly affect how well and how long we live. Educational attainment in particular is a strong predictor for future health outcomes.
• Chronic Disease: Diabetes and Heart Disease: Chronic diseases can be managed, and many are preventable. However, generational attitudes along with the ability
to obtain necessary health care services need to be addressed in order to allow community residents the opportunity to live a healthier life. Education, information, and improved access can have a significant impact in reducing the chronic conditions of residents.
• Poverty: poverty is linked with negative conditions such as substandard housing, homelessness, inadequate nutrition and food insecurity, and under-resourced schools. Poor
children and teens are at greater risk for several negative outcomes such as poor academic achievement, school dropout, abuse and neglect, behavioral and socioemotional problems, physical health problems, and developmental delays.

The proposed innovation project addresses almost all of the top community challenges including: mental health/substance abuse, chronic disease, and poverty. In addition, it addresses maternal/child health in an attempt to address health equality in that area. Finally, the innovation addresses three of the identified social determinants of health concerns: equity, transportation, and housing. Following is a discussion of the data utilized to identify the priority areas for the proposed innovation:

The mental health data that documents need in the communities include the number of days per month that respondents indicated their day was mentally unhealthy. All counties except Pike are significantly higher than the State and of top US performers as documented in the chart below:
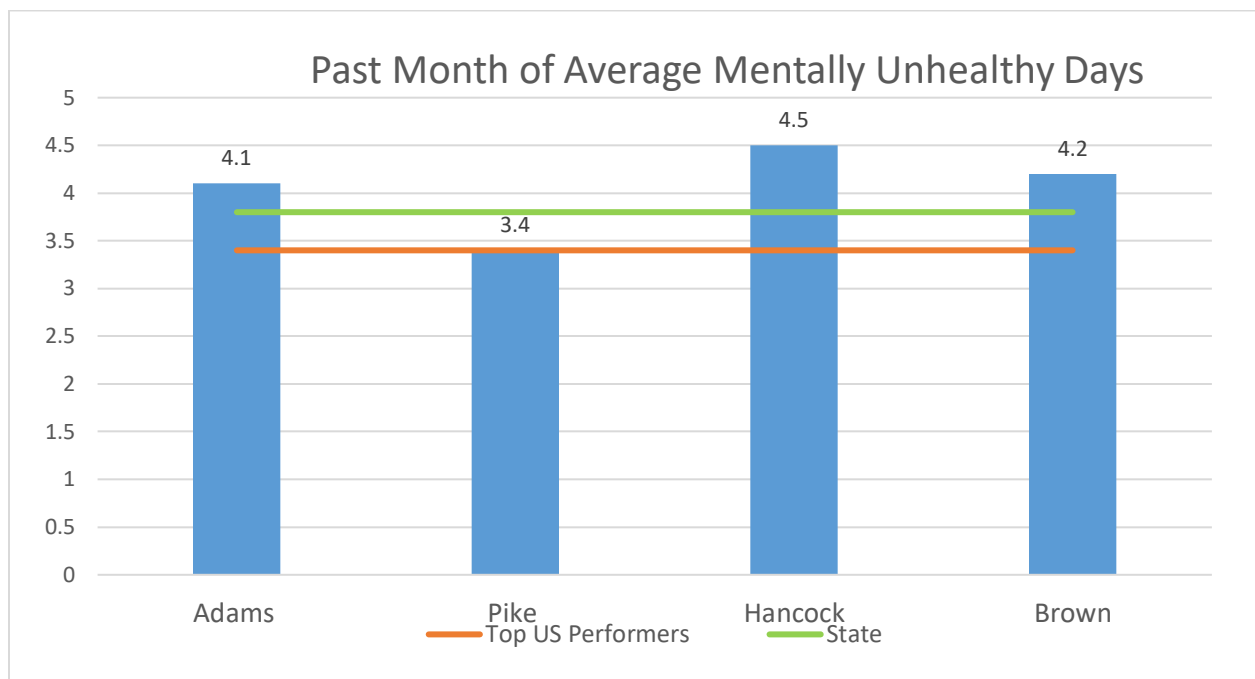

All of the counties report higher numbers than the state of Illinois and the top US Performers for the percentage of adults reporting 14 or more days of poor mental distress. Pike County is the highest at 16%:

Frequent Mental Distress

Percentage of adults reporting 14 or more days of poor mental health per month

Chart showing Frequent Mental Distress by county:
- Adams: 14
- Pike: 16
- Hancock: 14
- brown: 14

Top US Performers & Illinois State: 12 (orange line)

In addition, the number of Emergency Department visits related to mental and behavioral health disorders continues to increase and is 35% over the past five years
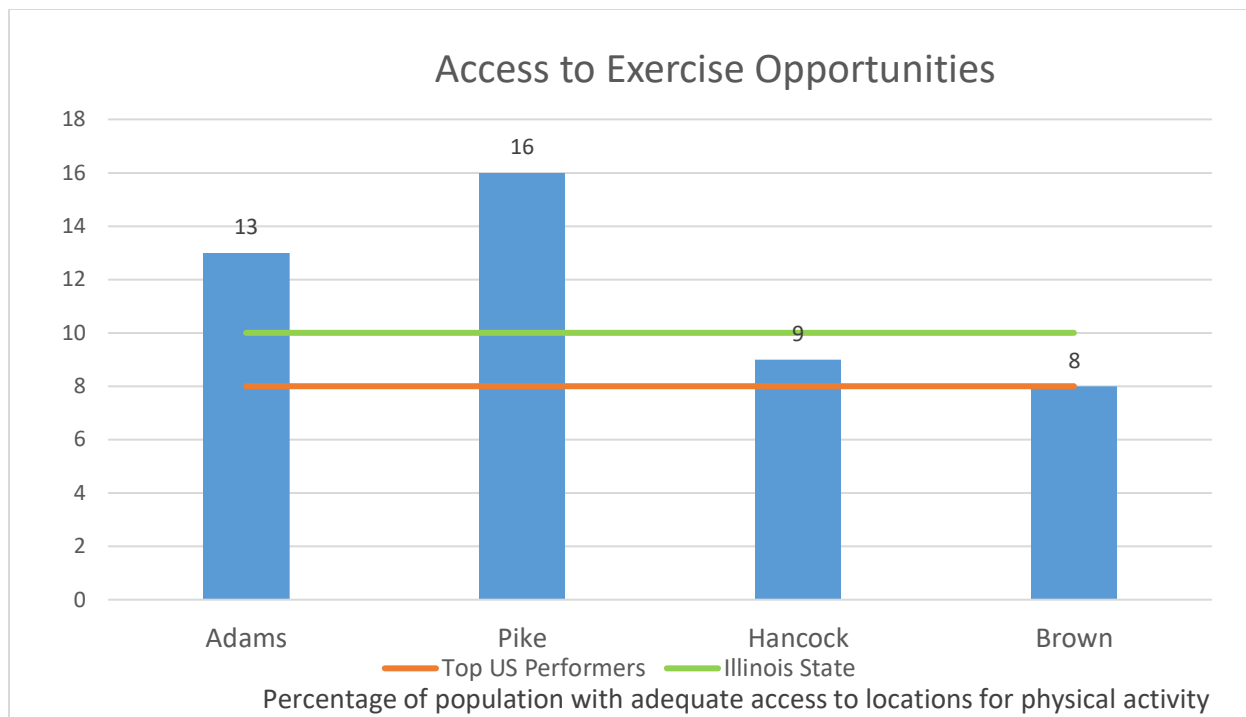
There are a variety of data sources that demonstrate the need for health care and the need for strategies to help the target poulation effectively manage chronic disease. The counties all have a higher obesity rate than the state, except for Brown County:

Obesity

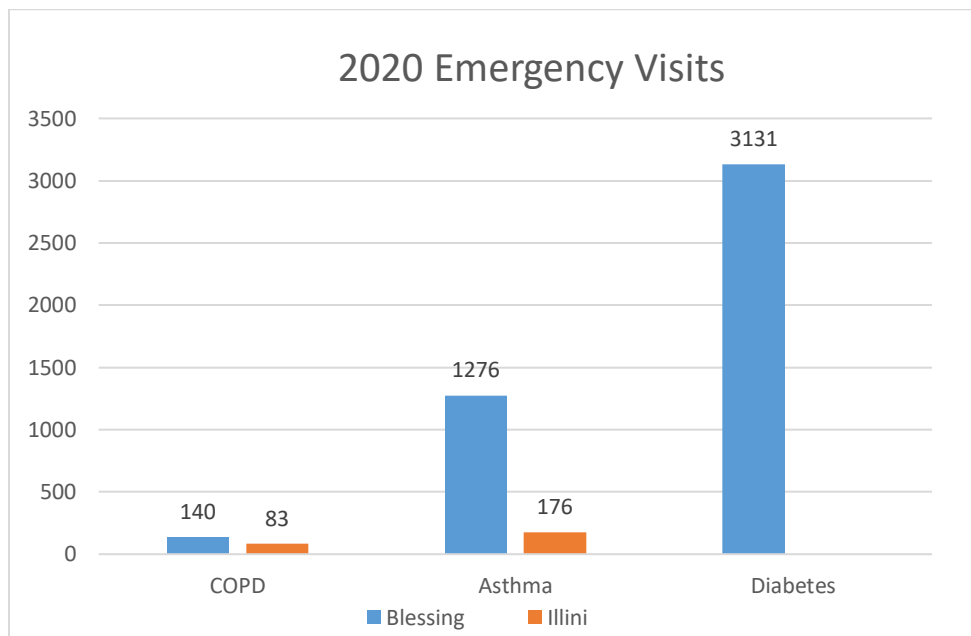Percentage of adults 20 and older that report a body mass index
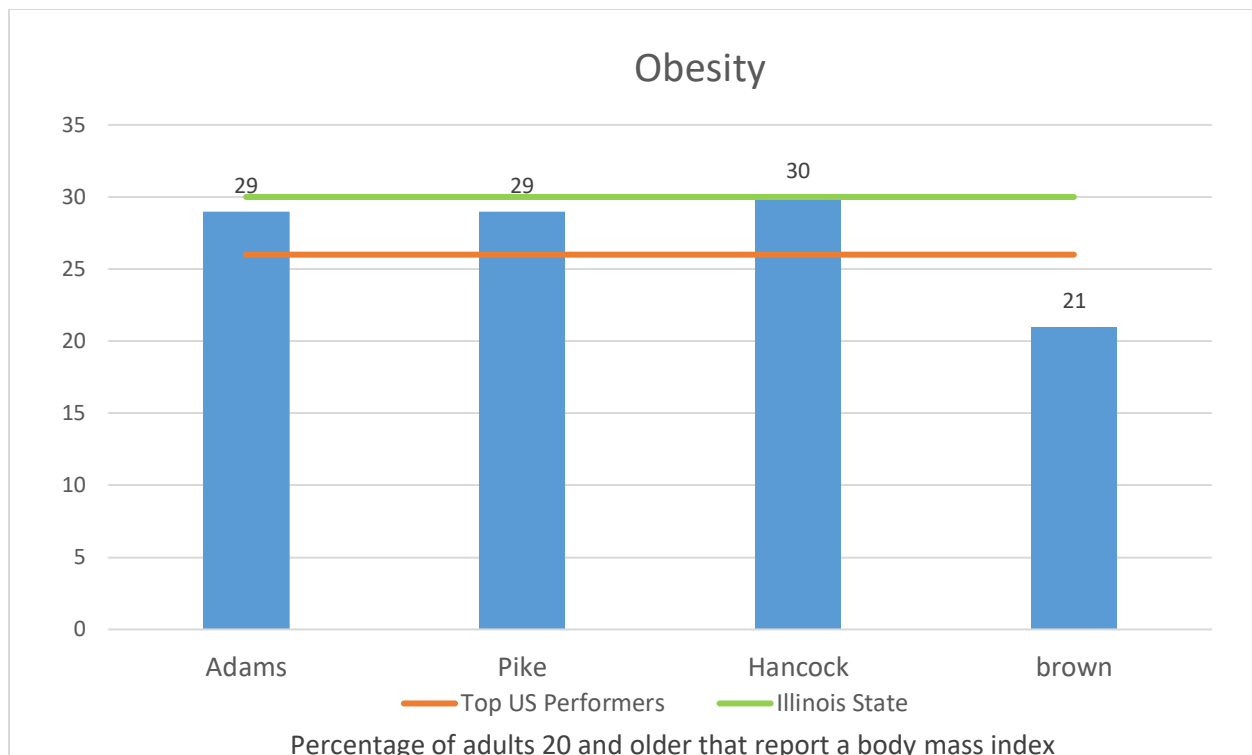
In addition to obesity, residents in the target area are physically inactive, with Adams County reporting 29% of adults age 20 and older that have no leisure time activity:

Physical Inactivity

Percentage of adults aged 20 and over reporting no leisure-time physcial
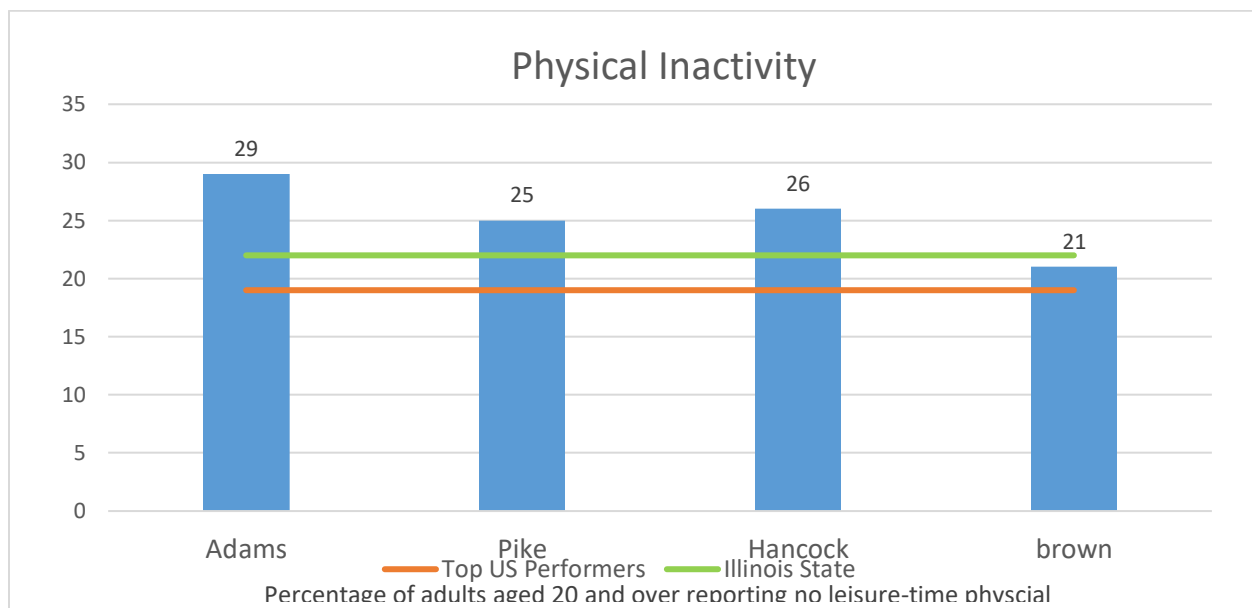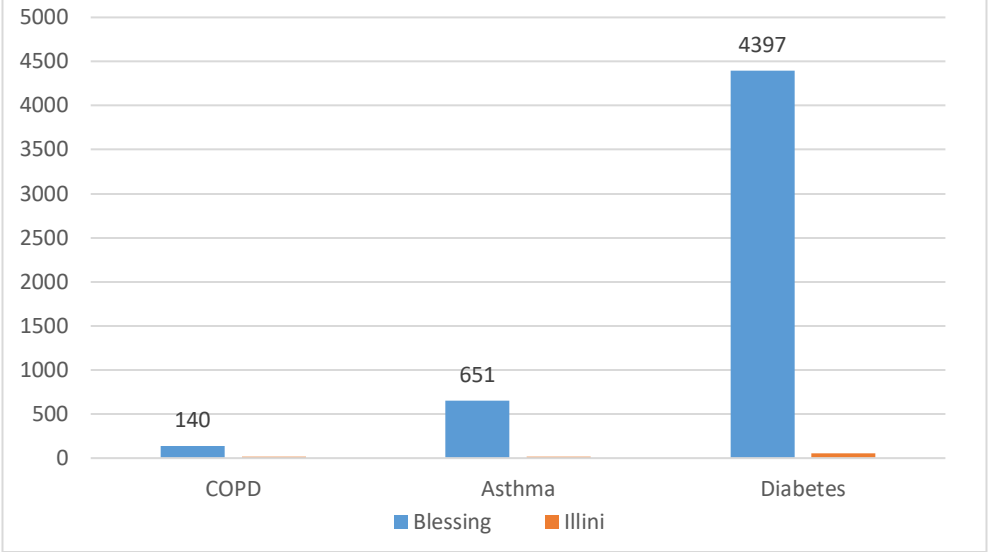
Finally, residents in the targeted areas report low opportunities to access exercise, with Brown County having only 8% of the population with access to exercise opportunities:

Access to Exercise Opportunities

Adams: 13
Pike: 16
Hancock: 9
Brown: 8

Top US Performers — Illinois State

Percentage of population with adequate access to locations for physical activity

Additionally, there are a high volume of emergency room and inpatient visits related to chronic conditions including COPD, asthma, and diabetes in the hospital setting – both inpatient and in the Emergency Department – as demonstrated by the following data:

2020 Emergency Visits

COPD: Blessing 140, Illini 83
Asthma: Blessing 1276, Illini 176
Diabetes: Blessing 3131
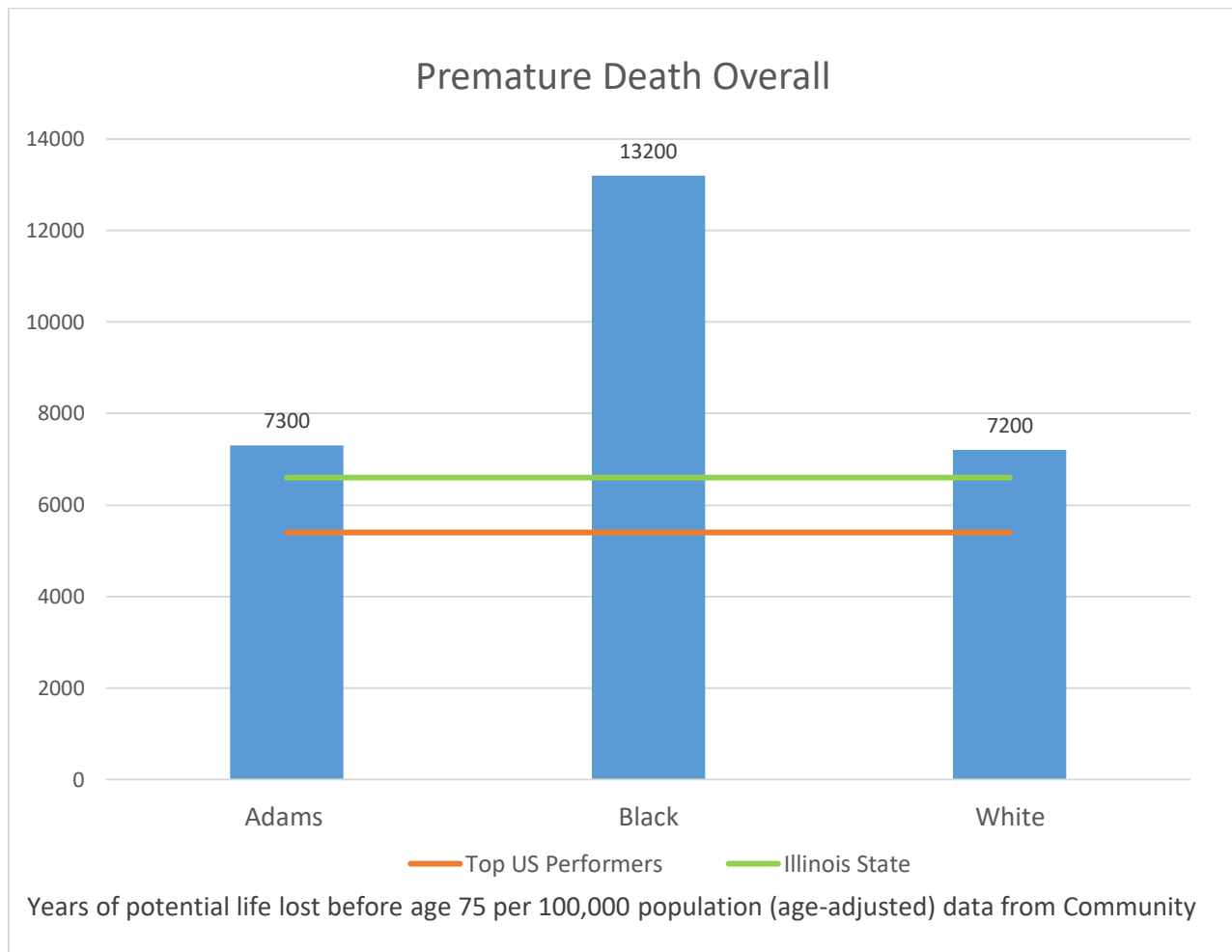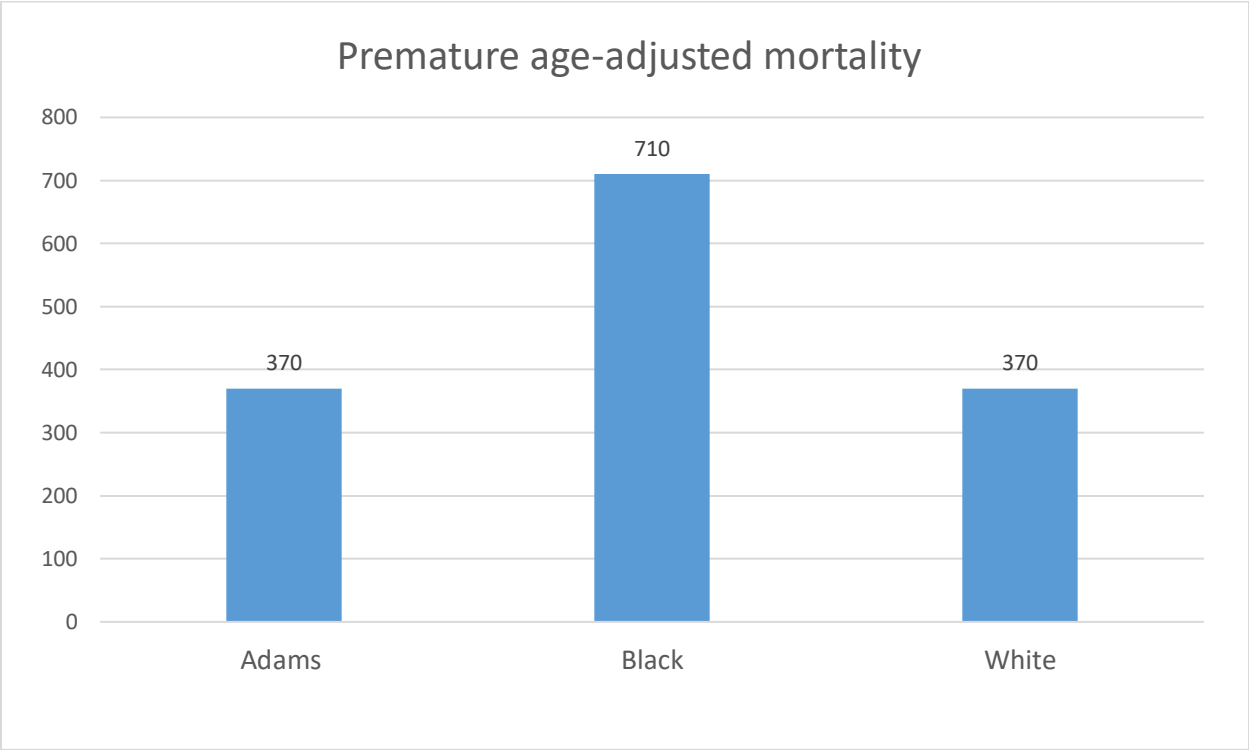
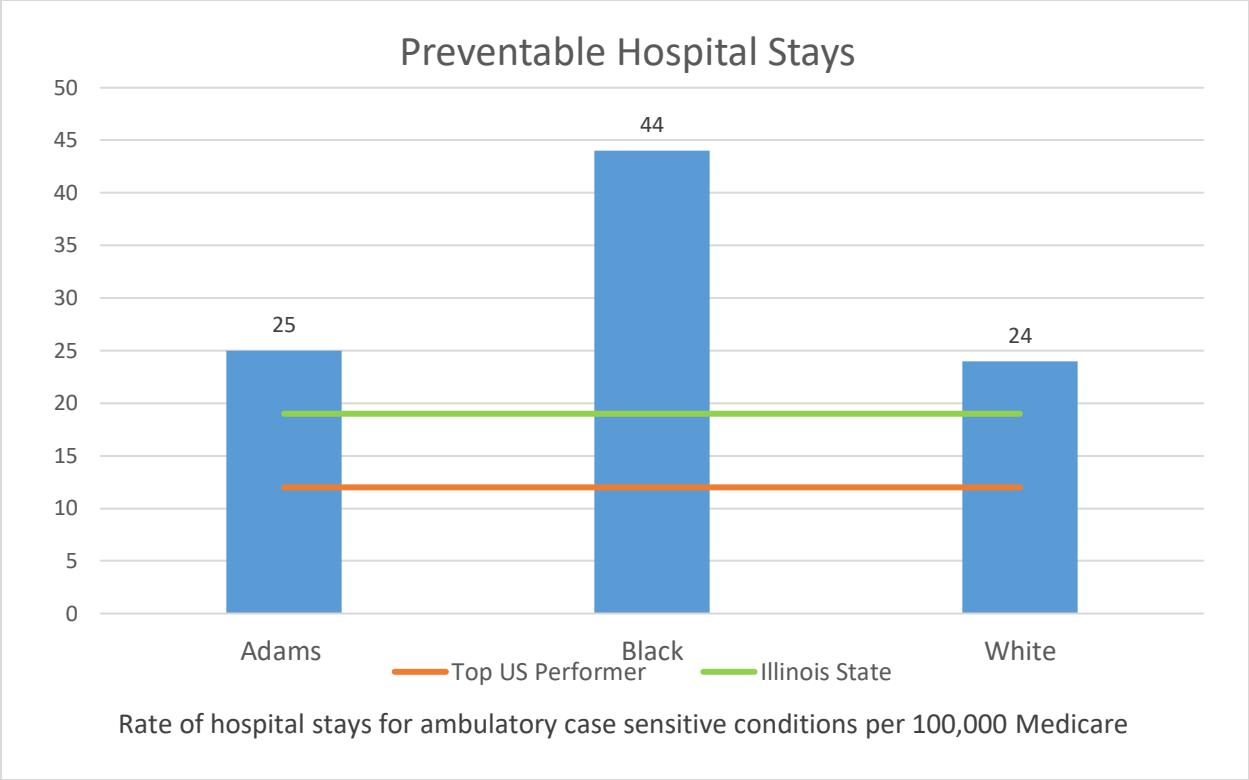Blessing   Illini

2020 Inpatient Visits

7. Health Equity and Outcomes

1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes. [1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Note: For all disparity data the data only includes Adams County as the data in the other targeted county numbers were too small to be reliable and reportable. It is anticipated that the data for the other targeted counties will be similar that of Adams County.
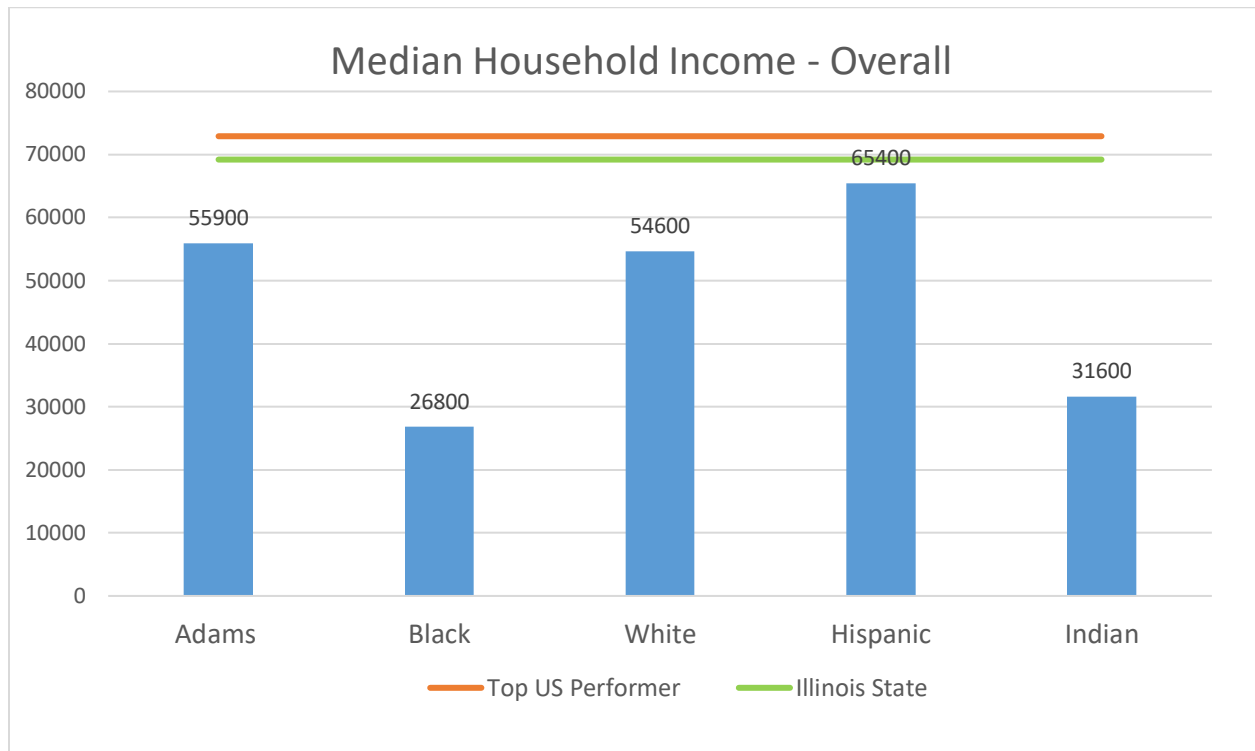
The health disparities that have identified that will be addressed through the proposed innovation include the following healthcare related indicators: Premature death, preventable hospital stays, premature age-adjusted mortality. All data demonstrate a concerning higher rate of incidence in the black population as compared to the overall population and the white population. All data demonstrate significant inequities as compared to the State of Illinois and Top US performers.

Premature Death Overall

Years of potential life lost before age 75 per 100,000 population (age-adjusted) data from Community

Preventable Hospital Stays

	Adams	Black	White
	25	44	24

— Top US Performer — Illinois State

Rate of hospital stays for ambulatory case sensitive conditions per 100,000 Medicare

Premature age-adjusted mortality

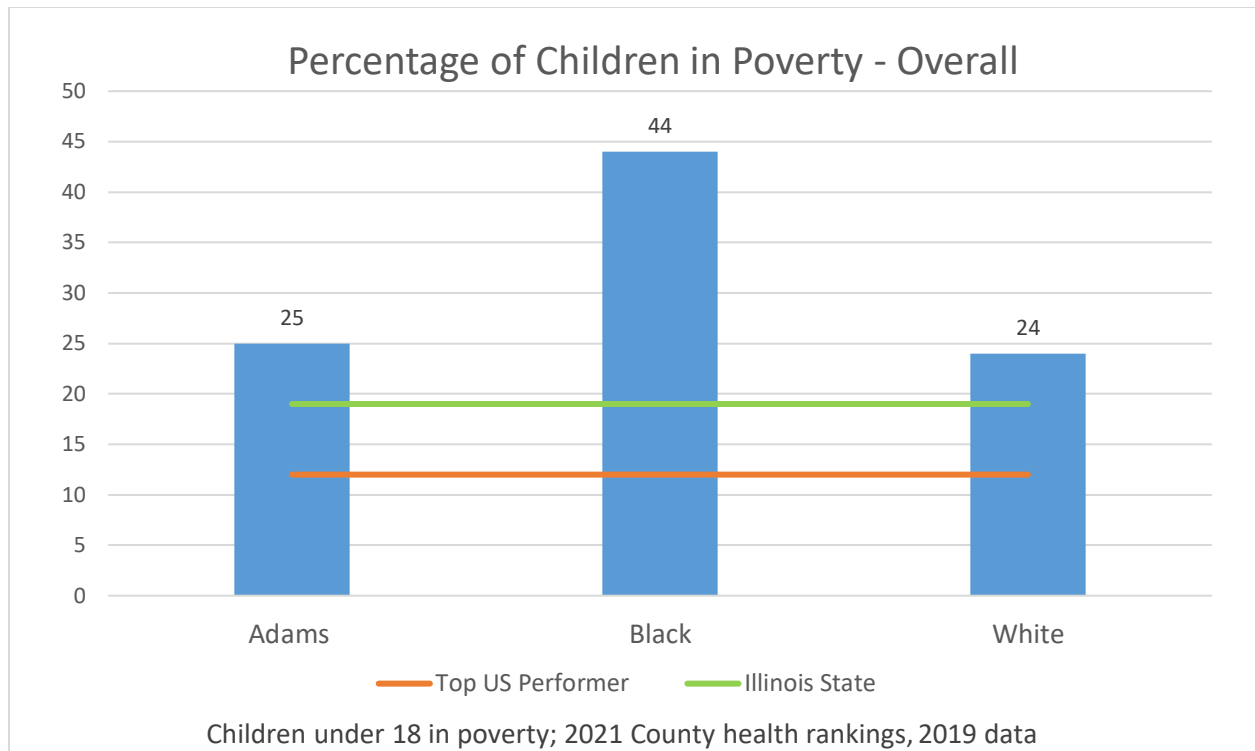|	Adams	Black	White
	370	710	370

In addition, the poverty data for the target area demonstrates inequities that must be addressed as well as shown by the median household income which demonstrates that the black and Indian population

have significantly lower median household income as compared the overall population, white and the Hispanic population. The income is also significantly lower than the state of Illinois and the top US Performers.

Median Household Income - Overall

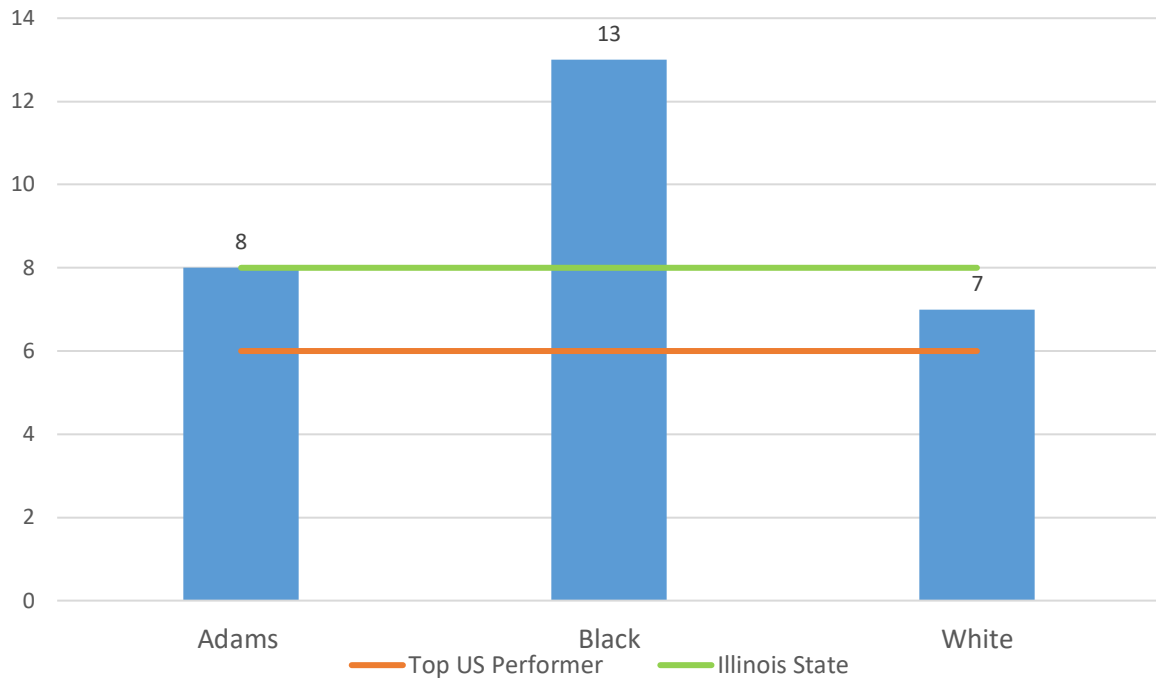| Category	Value
Adams	55900
Black	26800
White	54600
Hispanic	65400
Indian	31600

Legend: Top US Performer, Illinois State

Another inequity noted is the children under 18 who live in poverty – the black population is significantly higher than the overall population and the white population. It is also significantly higher than the State of Illinois and the top US Performers.

Percentage of Children in Poverty - Overall

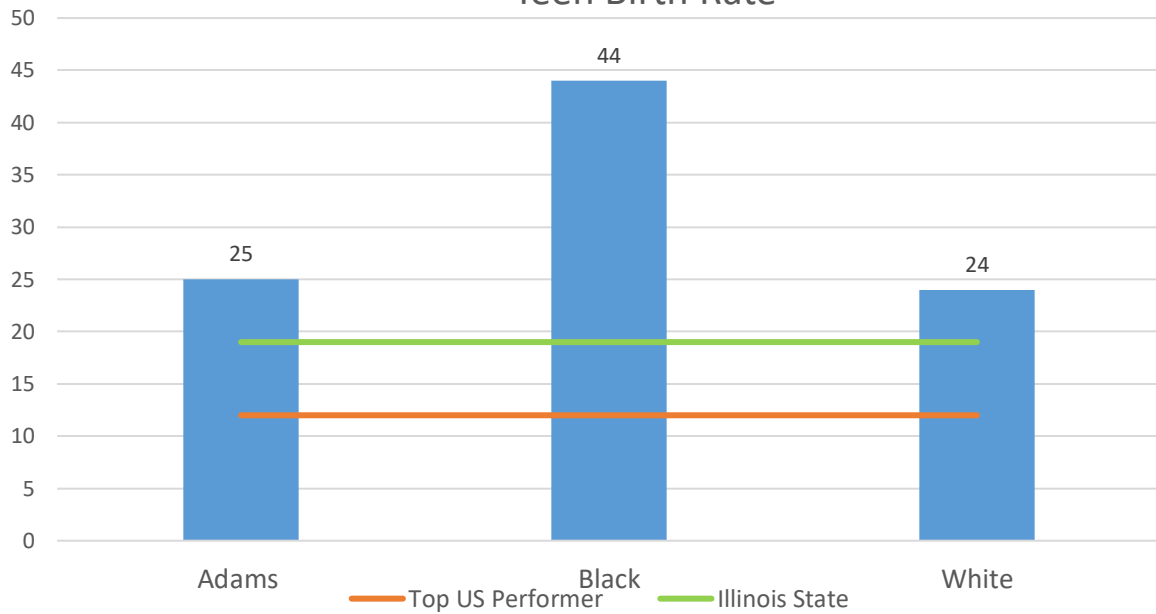Children under 18 in poverty; 2021 County health rankings, 2019 data

Other inequities were noted in the area of Maternal/Child Health. The two indicators that will be addressed through this proposal include: percentage of live births with low birthweight (<2500 grams) and the Teen Pregnancy rate. Findings indicated that the black population had negative results as compared to overall, while State of Illinois and Top US performers:
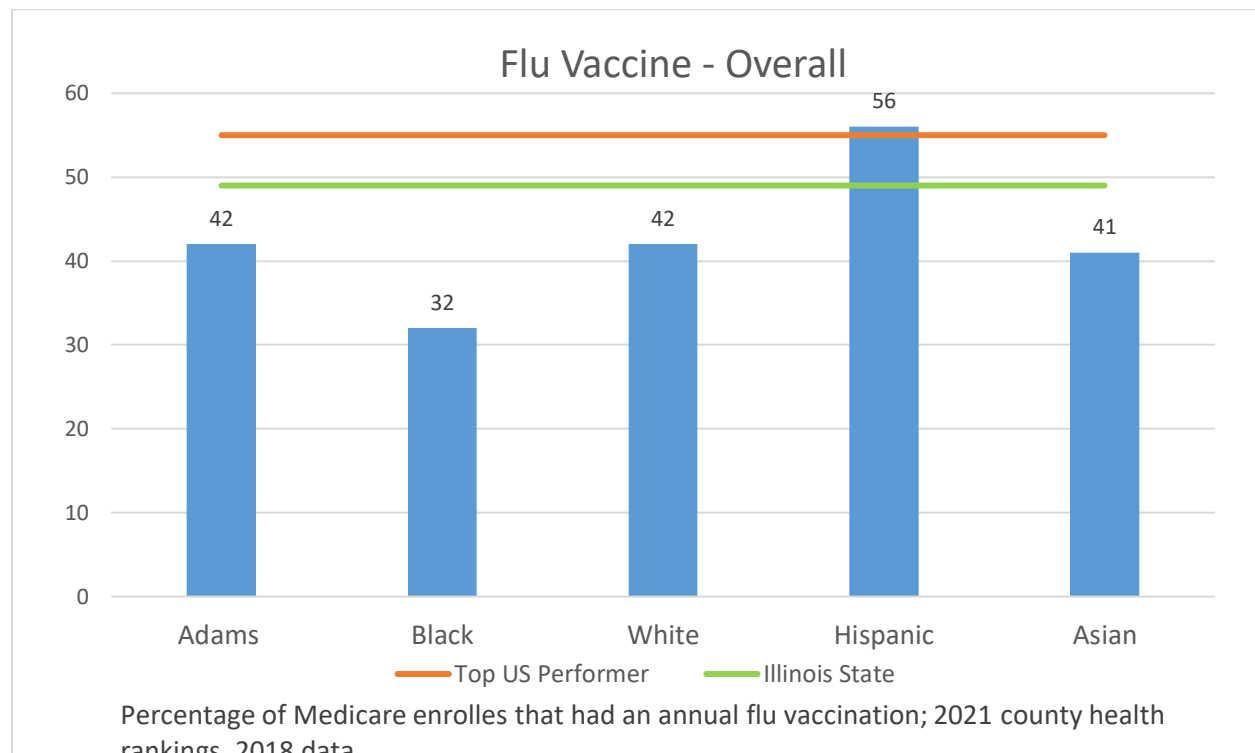
Low Birth Rate - Overall

	Adams	Black	White
Value	8	13	7

Legend: Top US Performer (orange line at 6), Illinois State (green line at 8)

Percentage of live births with low birthweight (<2500 grams); 2013-2019 County Health Rankings Data, 2021

Teen Birth Rate

	Adams	Black	White
Value	25	44	24

Legend: Top US Performer (orange line at 12), Illinois State (green line at 19)

Number of births per 1,000 female poupulation ages 15-19; 2021 county health rankings

A final area of inequity that will be addressed by the proposal is the rate of flu vaccination. The black population is lower than that of Adams County overall, the while population, the State of Illinois and of the Top US performers.

Flu Vaccine - Overall

Percentage of Medicare enrolles that had an annual flu vaccination; 2021 county health rankings, 2018 data

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting? [2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

The activities that will be implemented to address the disparities identified above include interventions to bring services to the target population. The interventions implemented through the proposed intervention will include expanding telehealth services to partners in the collaboration in order to increase their ability to serve patients in the remote areas, decreasing the need to travel. Telehealth services will include behavioral health interventions, remote patient monitoring to assist patients in monitoring their chronic disease and for primary and specialty care consultations. Secondly, access to primary and specialty care will be increased through the use of a mobile health unit to provide medical care to the highly remote, rural communities in the service area. In addition, a mobile unit will be used to provide primary and specialty care in the most remote areas of our target area. Another intervention strategy is to increase the use of Care on Demand services in the rural communities to allow convenient, 24/7 access to healthcare where the population resides. Blessing Health System has the foundation developed to offer Care On Demand services, which use telehealth providers to provide services when consumers need them. Five Kiosk service delivery centers will be provided in the geographic areas that are determined to be the most in need. The Kiosk will provide services to the targeted population where they live in order to reduce transportation needs. These tools are very effective in serving the

extremely remote, rural areas where there is not enough population for a provider to be present. Increasing access to dental health services will is also a strategy to increase access to care as data has shown a need for dental services in our area, particularly for the Medicaid insured population.

As with the other intervention strategies, a scorecard will be created to determine the impact of the access to care interventions on the identified barriers. Measurements including number of patients served, number of services provided, etc. will be tracked, and progress will be evaluated.

3. Why will the activities you propose lead to the impact you intend to have? [3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

We believe the interventions will be effective and will lead to positive, measurable results as they are evidence-based strategies which have proven to be successful in the past. The partners have a strong foundation built from which to deliver the proposed services.

9. Social Determinants of Health

A full 50% of a person's health outcomes can be attributed to social determinants of health (that is, factors such as education, economic stability, housing, access to healthy food, access to transportation, social support and environment). Given this, we are looking for collaborations that meaningfully address social determinants of health in coordination with physical and behavioral health. 1. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes. [1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Social Determinants of Health (SDOH) is defined by the U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality of life outcomes and risks. The community needs assessment identified the following SDOH as one of their top three most critical issues residents:
• Economic Insecurity
• Lack of access to healthy foods/lack of nutritional education
• *Lack of safe, affordable housing*
• Poverty
• Aging Infrastructure
• *Inequality*
• *Transportation*

Our collaborative members determined that the SDOH that will be addressed initially in the proposed innovation are: Lack of safe affordable housing, inequality, and transportation. These were selected due to members feeling they are the highest immediate needs at this time and that we would obtain the most benefit from addressing them initially through the proposed innovation. Additionally, members felt these inequities are those with the least amount of work being directed to them at this time.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting? [2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

The proposed innovation contains activities related to the identified social determinants of health inequities in our targeted communities:

Inequity – We will contract with ATW Health to guide us in assessing inequities and engaging the population to develop strategies to address the identified inequities. The goal of the collaboration that is related to this area is to develop an engagement strategy to address inequities, including racial, in the existing service delivery system and social determinants of health barriers that result in disparities in individuals' ability to access care. Three related strategies will be implemented to address this goal including: Measurement and Research—Identifying and Understanding Patient Population, Experiences, Outcomes and Disparities; Organizational Partnership—Working with Diverse Partners to Identify Problems and Potential Solutions and Care, Policy, and Process Redesign—Adapting to Meet Identified Needs Better. The measurable impacts that will be obtained from these activities are increase in the number of intervention areas identified, number of patients engaged in resolving issues, the number of interventions successfully implemented to address inequities, and the increase in the number of patients who receive services.

Transportation – We plan to contract with Integrity Secure Transport to provide transportation services to patients with transportation barriers so that they can attend their medical and social services appointments. Patients in need of the services will be identified from staff at the collaborating agencies. Staff from the collaborating entities will have the ability to schedule transportation for patient on-line using Integrity's scheduling system. In addition, we will explore additional options to address the transportation barriers using innovation techniques with the engaged target population. The measurable impacts that will be obtained from these activities are the number of rides/miles given and the number of patients served through the intervention.

Housing – We will contract with two providers to assist in meeting the housing needs of the community. Transitions of Western Illinois will provide access to transitional housing for patients transitioning from different levels of care who have no access to housing. The YWCA will provide supportive housing for longer- term solutions for those who need housing and are in a situation to be able to support their living arrangements with care management support to be successful.

A scorecard will be customized for the collaborative to identify immediate and measurable outcomes, and collaborative leaders will be trained on the use of the tool for ongoing performance management.

3. Why will the activities you propose lead to the impact you intend to have? [3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

The identified activities and contractors will meet the identified social determinants of health needs that have been identified. We will continue to assess needs and evaluate outcomes of the interventions to continuously evaluate the need for further interventions.

1. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care. [1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

The collaborative will implement activities to impact community- based support systems in place to guide and support individuals' barriers to access or appropriate use of available services through three strategies including: Enhancing the current community support services teams in each county to assist patients with *behavioral health needs*, expanding community health workers in the community to help patients effectively access and follow through with appropriate and effective use of *medical services,* implementing Family Connects Program to improve *Maternal and Child Health Outcomes* and develop care management capacity to identification, and providing targeted programing to high cost patients, patients who are experiencing transitions in care, and those who are high utilizers of the Emergency Department.

2. Do you plan to hire community health workers or care coordinators as part of your intervention? Yes No 2A. Please submit care coordination caseload numbers and cost per caseload (stratified by risk, if applicable). [2A - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Yes, we plan to hire community support workers for behavioral health support, community health workers, care managers and care coordinators as a part of the intervention. All staff will work with existing care coordination staff. New staff hired have clearly identified needs in the community needs assessment.   A collaborative, integrated system of care will be developed using existing and new care coordination staff. Caseloads are defined below:

Position	Quality	Caseload per position	Total Caseload
Community Support Worker	6.5	35 (lower due to intensity of behavioral health services provided)	228
Care Coordinator	3	100 (lower due to high cost claimant work, higher intensity of services needed.	300
Community Health Worker	6	200	600
Nurse Care Manager	5	150	750

Total caseload: 1,878

3. Are there any managed care organizations in your collaborative? Yes No 3A. Please list the names of the managed care organizations in your collaborative. 3A. If no, do you plan to integrate and work with managed care organizations? Yes No 3B. Please describe your collaborative's plans to work with managed care organizations. [3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

We do not have any managed care organizations in the collaborative. As the innovation evolves, we plan to integrate with the organizations to determine effective ways to collaborate effectively to meet the needs of the Medicaid population.

11. Minority Participation

1**. Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners. Note on BEP partners/vendors: If one of the members of your collaboration already contracts with a BEP-certified firm or a not-for-profit entity that is majorly controlled and managed by minorities, only include the services of the firm that will be used on this project. To be included, these services must increase the entity's volume of work above the level of services already provided to the collaborating member. Resource to help you search for/identify BEP-certified vendors in Illinois: If you are seeking BEP-certified entities to partner/collaborate with, you may consult our resource guide linked below on How to Look Up BEP-Certified Vendors in the State of Illinois. Download resource: How to Look Up BEP-Certified Vendors in the State of Illinois.pdf List entities here:**

ATW Health Solutions is a partner in the proposed intervention and is a U.S. Small Business Administration (SBA) 8(a), Women-Owned Small Business (WOSB) healthcare advisory and consulting firm based in Chicago, Illinois. Established in 2014, ATW Health Solutions has earned national recognition for its work transforming healthcare delivery systems from ordinary to best-in-class. With a focus on improving quality, safety, and health equity, ATW Health Solutions has partnered with public and privately held organizations and government agencies to transforming healthcare delivery systems locally and nationally. Founded by healthcare transformation expert and visionary Dr. Knitasha Washington, ATW Health Solutions is a values organization driven by bold aims and goals to improve healthcare for all.

While of the national focus about health disparities has been on building upon research, ATW Health Solutions approach to the work has been implementation science aligned with the work of the health care delivery system. ATW, since its inception, has teamed with governments, agencies, and industry to deliver products and services that are Raising Healthcare's Standard. ATW is an Illinois-based company that has established past performance and proven capabilities leading large-scale quality improvement initiatives that transform healthcare delivery.

2. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the

ongoing operation of your transformed delivery system. [2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

ATW Health Solutions proposes to partner with the Collaborative by providing technical support, training, and education to support its transformation efforts designed to address equity and patient/stakeholder engagement. ATW will support the collaborative by providing all staff and resources necessary to meet the following objectives:

Strategic Management

- Design and implement stakeholder engagement process and plans that reflect what matters most to all patients at each level of care for the collaborative entities (i.e., direct care/point of contact, policy and procedure, governance, and public and community policy).
- Apply racial equity metrics in scorecards for both annual operating plans and strategic plans; defend the business case for diversity
- Assess and develop individual capacity to effectively integrate racial equity metrics in management and leadership
- Communicate the importance of racial equity as a means of advancing a comprehensive population health management strategy

Organizational Leadership and Workforce Management

- Provide technical support that aligns importance of applying an equity lens in cross-functional, interdisciplinary settings as a means of advancing mission and exemplifying core values of the program.
- Collect and analyze workforce demographics, including position classification data on race, ethnicity, and language (REaL); establish diversity and inclusion
metrics in operations and governance
- Observe leadership characteristics that inspire inclusion and cultural humility

Quality and Performance

- Develop, implement, and evaluate person-centered quality improvement strategies that address the needs, perspectives, interests, values, and beliefs of all patients and families, including those from marginalized and disparate populations in the community.
- Examine causal factors of variation in clinical treatment and patient experiences and redesign health system delivery processes to align with more equitable strategies.
- Integrate racial / ethics equity concepts in measurement and quality improvement initiatives.
- Establish a data-driven systems approach to achieve equity in health care quality and safety outcomes as well as address barriers to promote more inclusive engagement of patients and families from diverse cultural, ethnic, or socioeconomic backgrounds including rural populations, veterans and other marginalized sub-populations.

ATW's approach to addressing equity and improving quality through health systems transformation is built on the principle that patients, families and their communities are fundamental partners in defining, designing, participating in and assessing the care practices and systems that serve them to assure they

are respectful of and responsive to individual patient preferences, needs and values. This collaborative methodology strategically integrates community engagement and patient engagement into a system thinking function that allows patient values to guide all clinical decisions and drive genuine transformation in attitudes, behavior and practice. Through our evidence-based strategies, we give voice to the voices least heard in your communities, activate patients both in the community and within the health system and develop a co-created model with the health system to deliver care.

Jobs

Existing Employees 1. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels. [1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.) New Employment Opportunities

Strategy one is focused on gathering data on the collaborating providers and documenting job levels based upon category, residence and benchmarking to assure that job levels are maintained and improved over the course of the proposed innovation. We are also working to gather data to assure the workforce adequately reflects the population served as defined in Objective1.1a. This objective is to establish a performance improvement management system to collect and assess data about the patients and families served by the collaborative, disparities in care quality and safety among them, social issues affecting the surrounding communities, and the collaborative's workforce and resource capacity. We will also document and monitor the use of services and supports related to the provision of culturally and linguistically appropriate services.

2. Please estimate the number of new employees that will be hired over the duration of your proposal.

The project will create 26.7 FTE new positions in the community. Positions that will be hired include : 6.5 FTE community support workers, 3 care coordinators, 6 community health workers, 1.2 pharmacy tech, 1.0 telehealth patient care coordinator, one virtual care quality analyst, 5.0 nurse care managers through the Adams County Health Department, 2.0 therapists, and 1.0 housing coordinator through the YWCA.

3. **Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve. [3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)**

Anticipated new employment opportunities are discussed previously and we will work to assure they adequately reflect the community we serve.

4. Please describe any planned activities for workforce development in the project. [4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

We do not have any planned activities for workforce development in the proposed innovation. There is a strong infrastructure of entities targeting on workforce development already in place in the community, led by the United Way of Adams County.

13. Quality Metrics

Alignment with HFS Quality Pillars In order to complete this section, you will need to reference the HFS Quality Strategy document linked below. HFS Quality Strategy: https://www.illinois.gov/hfs/SiteCollectionDocuments/IL20212024ComprehensiveMedicalProgramsQualityStrategyD1.pdf

1. **Tell us how your proposal aligns with the pillars and the overall vision for improvement in the Department's Quality Strategy. [1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)**

The proposed innovation is designed to improve quality while decreasing the costs of care for the Medicaid population. A major component is equity and assuring that the all segments of the population receive needed services. The project targets all populations served by Medicaid including those with behavioral health needs, women-and-infant health and those with chronic conditions and aligns with the population targeted in the HFS framework. The goals of the Department's Quality Strategy focusing on better care, healthy people/healthy communities and affordable care align well with the proposed innovation's goals. The proposed innovation addresses all of the identified pillars of improvement including maternal and child health, adult and child behavioral health, equity and community-based services and supports. The HFS Quality Strategy framework identifies twelve goals for improvement in the three pillars of improvement. Following is a discussion of the goals and how they are addressed through our proposed innovation:

Better Care

1. *Improve population health-* Population health strategies to increase quality and decrease cost of care included in the proposal include care coordination and telehealth strategies. The goal is to increase patient's ability to receive the right level of care in the right setting.
2. *Improve access to care-* A variety of initiatives are included in the proposed innovation strategy to improve access to care including: increase access to telehealth, provide primary and specialty care through use of a mobile unit, 24/7 access through Blessing Care on Demand, Increase access to dental care
3. *Increase effectiveness of care coordination-* The proposed innovation will greatly enhance the ability of the care coordination programs to be effective through hiring community support workers to address more intensive behavioral health needs of patients, hiring community health workers; hiring care managers to focus on transitions of care, emergency room, as well as high cost and utilizers. The care coordination initiatives will form a cohesive team to collaboratively address the patient needs.

4. *Improve participation in preventive care and screenings-* The access to care initiatives identified above will provide preventive care and screenings through the services provided through telehealth, the mobile unit, and Blessing Care on Demand. The inequity of flu vaccination will be addressed.
5. *Create consumer-centric healthcare delivery system:* One of the strategies of ATW Health and Do Tank involves forming partnerships to working with diverse partners to identify problems and potential solutions and care, policy, and process redesign—adapting to meet identified needs better.
6. *Identify and prioritize to reduce health disparities:* ATW Health and Do Tank will assist us in to develop an engagement strategy to address inequities, including racial, in the existing service delivery system and social determinants of health barriers that result in disparities in individuals' ability to access care.
7. *Implement evidence-based interventions to reduce disparities:* The strategies included in the innovation are evidence-based and proven to be effective in reducing disparities. New innovations will be generated as well through the patient engagement work that will be done in order to accomplish the innovation's goals.
8. *Invest in the development and use of health equity performance measures:* All measures will be tracked to demonstrate positive outcomes in health equity performance measures that have been identified.
9. *Incentivize the reeducation of health disparities and achievement of health equity-*We will contract with ATW Health to guide us in assessing inequities and engaging the population to develop strategies to address the identified inequities. Collaborative partners are incentivized to participate through participation in the program funds and resources.
10. *Affordable Care*
11. *Transition to value and outcome-based payment:* The goals of the innovation are to utilize population health strategies to decrease the costs of care and enable more effective management of outcomes for the target population.
12. *Deploy technology initiatives and provide incentives to increase adoption of electronic health records (EHRs) and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management and data integration-* Entities have appropriate and aligned EHR's. The collaborative will work to share data and measure outcomes effectively.

2. Does your proposal align with any of the following Pillars of Improvement?

2A. Maternal and Child Health? Yes No Maternal and Child Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy. [Maternal and Child Heath - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Yes. Applicable Quality Measures:

1. *Reduce preterm birth rate and infant mortality*
2. Increase Immunization rates for infants and children

2B. Adult Behavioral Health? Yes No Adult Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy. [Adult Behavioral Health - Optional] Please upload any documentation or visuals you wish to submit in support of your Page 26 of 32 Healthcare Transformation Collaboratives For Reference Only response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Yes. Applicable Quality Measures:

1. Improve behavioral health services and supports for adults
2. Improve transitions of care from inpatient to community-based services
3. Improve care coordination and access to care for individuals with alcohol and/or substance abuse disorders

2C. Child Behavioral Health? Yes No Child Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy. [Child Behavioral Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Yes. Applicable Quality Measures:

1. Improve behavioral health services and supports for adults
2. Improve transitions of care from inpatient to community-based services
3. Reduce avoidable psychiatric hospitalizations through improved access to community based services
4. Reduce avoidable emergency department visits by leveraging statewide mobile crisis response

2D. Equity? Yes No Equity: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy. [Equity - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

1. Increase Preventive Care Screenings

2E. Community-Based Services and Supports? Yes No Community-Based Services and Supports: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy. [Community-Based Services and Supports - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

1. Adults' Access to Preventive/Ambulatory Health Services

3. Will you be using any metrics not found in the quality strategy? Yes No 3A. Please propose metrics you'll be accountable for improving and a method for tracking these metrics. [3A - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.) Note: Once metrics

are agreed upon in the negotiated funding agreement, HFS will proceed to establish a baseline for the service community, a tracking process, and negotiated improvement targets

No

14. Milestones

For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.) The timeline should be in months from award.

15. Budget

1. Number of individuals served each year (1-5)

2. Alternative Payment Methodologies

Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs.

We intend to demonstrate the cost effectiveness of a new model inclusive of an all-health approach which could be marketed to MCOS using a new payment methodology. An alternative payment model would continue efforts of the organizations to effectively implement cost savings through more effective, preventive care and decreasing high cost services for the target population. This methodology will be explored as we work on sustainability.

16. Sustainability

Include a narrative that describes how your budget will decrease reliance on Transformation funding over time and how reimbursements for services and other funding sources will increase and establish sustainability over time. (i.e. how will your project continue to operate without HTC funding?) In particular, include how services that address social determinants of health will be funded on an ongoing basis (for example, through existing payment models, alternative payment methodologies for Medicaid services, or through other funding sources). In your narrative, highlight any key assumptions that are critical to making your project sustainable.

The proposed innovation is the beginning of an unprecedented engagement with the community that we are trying to serve. The innovation will demonstrate how increasing access to care options including the use of technology to deliver the services, support patients with receiving services through effective care coordination, and addressing social determinants of health will result in an effective, decreased cost of care which will enable us to sustain the services that are provided. We will monitor the outcomes of the project to demonstrate a cost savings and health status improvement. This data will be utilized to leverage potential support of the innovation. With a population health focus, reducing these costs is essential for the future. The outcomes report will include cost savings from the project to justify continuation of the activities to improve efficiency and achieve cost savings.

Alternative Payment Models will be explored and potential expansion of billable service opportunities with Managed Care Organizations that we contract with will be explored.

Decreased reliance on Transformation funding is demonstrated over time based upon initial purchase of equipment, development of procedures, etc. As services are initiated and billing is implemented, the income will contribute to the proposed project.

We recognize that social determinants of health are not funded through existing fee for service methodologies. We will gather data and utilize the expertise of the United Way to assist us in community organizing to develop collaborative solutions to continue to address these important needs. Housing and transportation have been identified as community priorities and community action plans are being developed to address these important issues.